# Title II Comprehensive HIV/AIDS Care and Services Plan

for Ryan White Title II Funded Services
in Utah

2003 – 2004

Prepared by:
The Utah Department of Health for the
HIV Treatment and Care Planning Committee
January 2003

This is a copy of the Title II Comprehensive HIV/AIDS Care and Services Plan produced by the Utah Department of Health, Bureau of Communicable Disease Control with the assistance of the HIV Treatment and Care Planning Committee.
Additional copies may be obtained by contacting the
State HIV/AIDS Treatment and Care Program Office at (801) 538-6096 or 1-800-537-1046.

## ***Shared Vision for the Title II Comprehensive HIV/AIDS Care and Services Plan***

***The vision for the Title II Comprehensive HIV/AIDS Care and Services Plan is to ensure the access of quality treatment and care in a manner that ensures dignity for people affected by HIV disease.***

## ***Guiding Principles for the Committee Designing this Comprehensive Plan***

***As a committee, we will strive to create a plan that will commit resources to:***

- ***Serving the under-served***
  - ***Ensuring access to treatment and supportive care***
  - ***Adapting to changes in the health care system***
  - ***Documenting outcomes/results and evaluation***

## ***Mission Statement for the Committee Designing this Comprehensive Plan***

***The Treatment and Care Planning Committee provides community perspectives, advice and recommendations to the Treatment and Care Program in the planning, development and allocation of resources for a comprehensive, client centered continuum of care for people affected by HIV disease.***

# 2002 HIV Treatment and Care Planning Committee Members

| | |
|---|---|
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| **Kelly Byrnes** | **Consumer, Rural** |
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# Subcommittees
# 2002

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## Resource Allocation & Evaluation Subcommittee
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## Needs Assessment Subcommittee
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Karen Kone
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Linda Johnson – chair
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Jodie Pond
Rita Schluter
Maggie Snyder
Paula Wolfe

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Jodie Pond

## Goals & Objectives Subcommittee
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Jodie Pond – chair
Elaine Dahlgren

## Comprehensive Plan Subcommittee

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Greg Hardin
Russell Jensen
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Michael G Nelson
Jodie Pond – chair (interim)

## Ad Hoc Dental Subcommittee

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Greg Hardin
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Jodie Pond
Karen Kone
Wanda Gutierrez

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## With special thanks to our additional participant(s):

| | |
|---|---|
| **Diane Hamilton** | **Facilitator** |

**We would like to express our deepest gratitude to all the persons living with HIV and AIDS, their families, friends and caregivers who shared their opinions with us. The valuable information they have provided has become the foundation of this plan.**

## LIST OF TABLES

## Acronyms and Definitions Used Within This Document

**ADAP** – AIDS Drug Assistance Program

**AIDS** – Acquired Immunodeficiency Syndrome

**CPC** – (HIV Prevention) Community Planning Committee

**HIV** – Human Immunodeficiency Virus

**HOPWA** – Housing Opportunities for People Living With HIV/AIDS

**PLWH/A** – People Living With HIV/AIDS

**Ryan White CARE Act** – The Ryan White Comprehensive AIDS Resources Emergency Act

**SCSN** – The Statewide Coordinated Statement of Need

**Tx** – Treatment

**UDOH** – Utah Department of Health

# EXECUTIVE SUMMARY

The Title II Comprehensive HIV/AIDS Care and Services Plan, developed by the HIV Treatment and Care Planning Committee with the assistance of the Utah Department of Health, Bureau Communicable Disease Control, is the framework for the provision of care services during 2003 through 2004 for people living in Utah with HIV and AIDS. The Comprehensive HIV/AIDS Plan is divided into three major sections, ***(1) Where we are: A description of HIV/AIDS throughout Utah, (2) Where we are going and how we will get there,*** and ***(3) Monitoring our progress.***

The first section of the Comprehensive HIV/AIDS Plan addresses the state of the epidemic, describes service needs, identifies fiscal and service resources, outlines service priorities, and describes the barriers encountered by people seeking HIV care services. The second section discusses the history of the epidemic in Utah, describes the HIV Treatment and Care Planning Committee's operations, planning process, vision and guiding principles, and identifies the goals and objectives for 2003 through 2004. The third section discusses how the ongoing monitoring of the epidemic and Comprehensive HIV/AIDS Plan evaluation processes will occur.

## SECTION A

### *Overview of the Epidemiologic Profile*

The Wasatch Front area accounts for about 77% of all persons living with HIV/AIDS in Utah. The number of new cases of HIV/AIDS in Utah has continued to decline. Despite declines in the numbers of newly reported cases in HIV and AIDS, the number of people living with HIV or AIDS continues to increase. The number of deaths from HIV/AIDS in Utah decreased by 83% from a peak of 131 in 1995 to 22 in 2001 (Table 4). Data from the last several years shows little change in the overall pattern of HIV/AIDS cases when analyzed by sex, age and risk group.

- The majority of cases occur in men who have sex with men.
- The second largest risk is injecting drug use (IDU).
- Most persons living with HIV or AIDS in Utah are in the age group of 20 - 39 years of age.
- Although the majority of HIV/AIDS cases occur among White persons, there is a general shift toward an increasing percentage of HIV/AIDS cases among communities of color.
- The risk remains much higher among Black and Hispanic populations.
- The number of HIV/AIDS cases reported among Black persons increased 63% from 1997-1998 to 1999-2000. Most, but not all, of the increase can be attributed to increased cases among Black persons who immigrated to Utah from Africa.

***Highlights of the Needs Assessment***

Results of the Needs Assessment were based on the responses of the valid 273 surveys. Respondents indicated the top five most used individual services were:

- Doctor Visits for HIV/AIDS (83.9%)
- CD4 Count/Viral Load (22.3%)
- HIV/AIDS Medications (22.3%)
- Information on Treatment of HIV/AIDS (18.3%)
- Help Taking Medications & Dealing With Side Effects (17.9%)

Respondents indicated the top five most needed individual services were:

- Vitamins /Supplements (25.6%)
- Dental Care (22.3%)
- Nutrition Education (22.3%)
- Legal Assistance (18.3%)
- Vision Services (17.9%)

***Summary of the Fiscal Resource Inventory***

The fiscal resource inventory outlines the available resources throughout the state by funding stream, service category, provider/agency, and services provided. Total identified funds are provided through Title II, III, and V, and HOPWA. The budget totals of funds identified are:

| | | |
|---|---|---|
| Title II | $ 3,111,672.00 | (Table 18) |
| Title III | $ 773,234.00 | (Table 20) |
| Part F | $ 149,979.00 | (Table 21) |
| HOPWA | $ 199,989.00 | (Table 22) |

***Profile of the Service Priorities***

The continuum of care and service priorities are not consistent throughout the state due to regional differences and number of HIV/AIDS cases. The HIV Treatment and Care Planning Committee was able to identify HIV service gaps by researching and conducting a Gap Analysis for PLWH/A in Utah.

In small group format the Committee Members discussed priority setting perspectives and the diverse needs of consumers. Bridging the gap between existing and ideal continuum of care for all areas of the state is based on adequate funding levels.

***Synopsis of the Barriers to Care***

In September 2000, the Statewide Coordinated Statement of Need Committee met to identify the issues and barriers to effective HIV/AIDS services. Barriers to care have been identified by the following categories: case management coordination, changes in eligibility criteria, economic issues, stigma, and cultural sensitivity.

Other major service delivery issues include:

- Insurance issues, including coverage issues or lack of coverage, co-pays, deductibles, spend downs, and employment issues associated with insurance coverage.
- Continuation of life issues (longer life expectancy), especially the need for extended supportive services, return to work issues, and quality of life needs.

**SECTION B**

***Utah's Response to the Epidemic***

Reported cases of HIV and AIDS in Utah have declined since 1993. Although there has been a recent declining incidence of new cases of HIV and AIDS, the number of people living with HIV disease has continued to increase. This has greatly focused our efforts toward treatment and care, HIV prevention interventions, community participation and resource utilization.

The Ryan White CARE Act was created to establish services for patients with Acquired Immunodeficiency Syndrome (AIDS) or HIV who would otherwise have no access to health care. It was meant to provide emergency relief funding to communities with the highest number of reported AIDS cases.

The Utah Department of Health first proposed an integrated treatment/care and prevention education planning group in September, 1999. The goal of this integration was to improve and enhance participation and resource utilization in HIV prevention and care.

The purpose of the Utah HIV Planning Advisory Council (The Council) is to oversee the development of the annual Comprehensive HIV/AIDS Plan. The Comprehensive HIV/AIDS Plan serves as the guiding document for policy makers, health planners and community representatives.

***Highlights of the Treatment and Care Committee's Visions and Guiding Principles***

The Treatment and Care Planning Committee determined that all persons living with HIV/AIDS should be the focus of the planning process. The vision statement for the Title II Comprehensive HIV/AIDS Care and Services Plan is to:

> ***Ensure the access of treatment and care in a manner that ensures dignity for people affected by HIV disease.***

The guiding principles, which led the committee in developing the Comprehensive HIV/AIDS Plan, include:

- ***Serving the under-served:*** All persons living with HIV/AIDS will be offered access to care that is appropriate and broad in scope throughout all stages of their illness.

- ***Ensuring access to delivery of treatment and supportive care:*** The Comprehensive HIV/AIDS Plan's coordination of care will meet the needs of, and be accessible to, all populations with HIV/AIDS, all communities, all cultures, and in all geographic locations of Utah.

- ***Adapting to changes in the health care system:*** The Comprehensive HIV/AIDS Plan's delivery of this system will be flexible, innovative, and efficient in accordance with community-defined standards of care.

- ***Documenting outcomes/results and evaluation:*** The Comprehensive HIV/AIDS Plan will be sustained and supported through community-based collaboration and public/private partnerships with technical assistance to assess client needs, develop and manage cost effective programs, and evaluate services delivered.

***Summary of the Goals and Objectives for 2003 through 2004***

The five areas of essential services and their accompanying goals and objectives established by the committee are designed to provide for the development, organization, coordination and operation of a more cost effective and efficient system for the delivery of essential services to individuals and families with HIV disease.

## SECTION C

### *Overview of the Evaluation Process*

Evaluation is an essential element of the Comprehensive HIV/AIDS Plan. The HIV Treatment and Care Planning Committee and the Utah Department of Health, Bureau of Communicable Disease Control have the primary responsibility for monitoring the progress of the Comprehensive HIV/AIDS Plan's implementation. Throughout the next year (2003-2004), these two entities will monitor the progress toward achievement of the goals and objectives, continue to gather information and update the Comprehensive HIV/AIDS Plan on a yearly basis, and evaluate the HIV Treatment and Care Planning Committee's planning process.

# SECTION A WHERE WE ARE: A DESCRIPTION OF HIV/AIDS THROUGHOUT UTAH

## I. Epidemiologic Profile

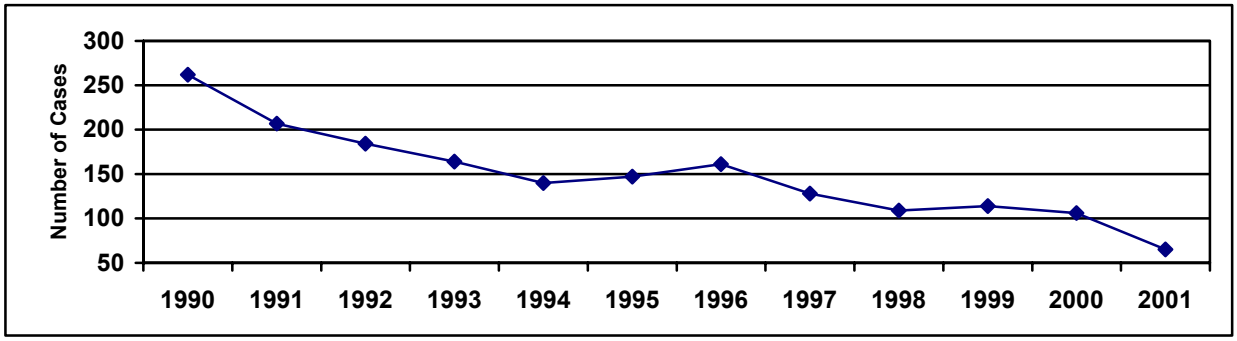
This section presents the epidemiological profile of HIV infection and AIDS in Utah. The overview describes the epidemiological trends among specific at-risk populations in the state. This is followed by a demographic description of the HIV/AIDS cases along the Wasatch Front (Davis, Weber, Salt Lake and Utah counties) and in all of Utah. Finally, a discussion of survival trends of people with AIDS.

### *Overview of HIV/AIDS Epidemiology in Utah*

Approximately 2.2 million people reside in the State of Utah. The major metropolitan areas of the state are located along the Wasatch Front, a four county area at the western base of the Wasatch Mountains. The remainder of the state is considered rural. As a result, Utah can be divided into two geographic regions: the Wasatch Front and rural/frontier counties.

Most of our understanding of the occurrence of HIV/AIDS comes from case surveillance. AIDS has been a reportable disease in Utah since 1983, and HIV since 1989. For most of the analysis in this report, HIV and AIDS have been combined. Reported cases of HIV/AIDS in Utah have declined since 1993. This trend differs slightly from the national trend. While AIDS cases continue to decline nationally, thanks in part to new medications, HIV cases are on the rise. The incidence rates in Utah have decreased from a peak of 15.2 cases per 100,000 (262 cases) in 1990 to 3.3 cases per 100,000 (75 cases) in 2001.

**Table 1.**
**Combined HIV and AIDS Cases in Year of First Report, Utah 1990-2001.**

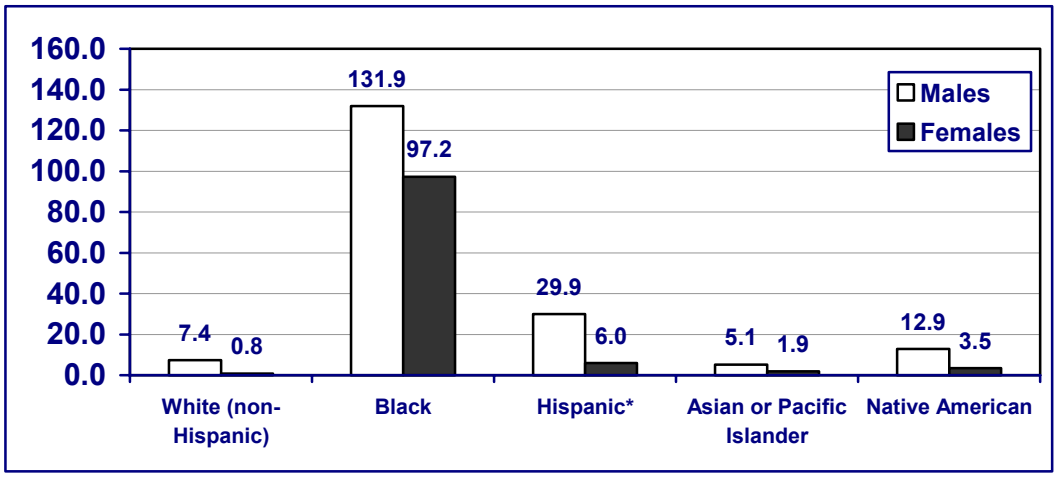



- Numbers of cases reported during 1991 and 1992 were artificially high due to a database error.
- Cases of HIV and AIDS were classified in the year they were first reported as either HIV or AIDS.

Source: Bureau of Communicable Disease Control, Utah Department of Health

Although the majority of HIV and AIDS cases occur among White persons there is a gradual shift toward an increasing percentage of HIV/AIDS cases among communities of color. The risk (rate per 100,000 persons) remains much higher among Black and Hispanic persons. Highest rates were found among black men (131.9 per 100,000 persons) and Black women (97.2 per 100,000). Of the 70 Black persons reported with HIV/AIDS during the past four years, 1998-2001, 44 (63%) are immigrants from Africa. The rate for Hispanic men was also high (29.9 per 100,000). Rates for American Indian and Asian/Pacific Islander people were based on very few cases and should be interpreted cautiously.

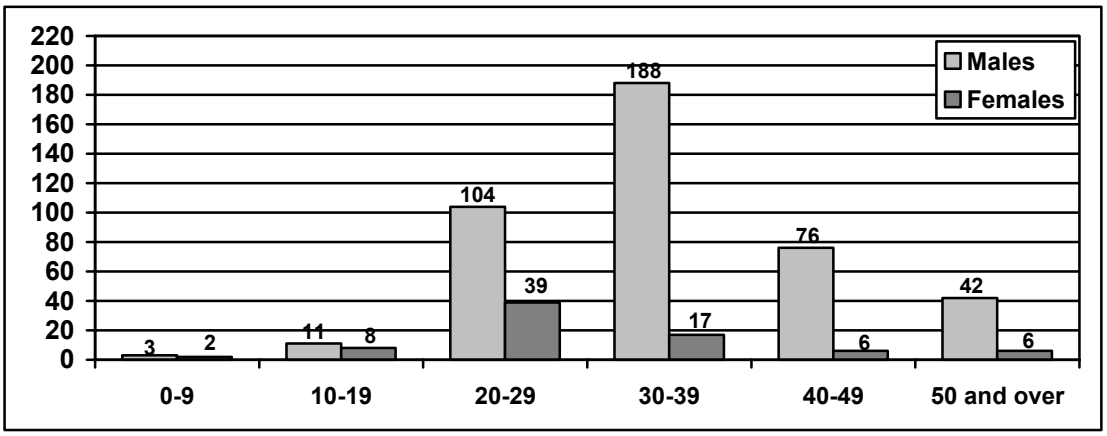
**Table 2.**
**Rate per 100,000 Persons with HIV/AIDS by Race/Ethnic Group and Sex, Utah 1998-2001.**




* Race and Ethnicity are separate, overlapping concepts, but for this presentation, people of Hispanic ethnicity were considered as a separate group.
Source: Bureau of Communicable Disease Control, Utah Department of Health

Age and sex, while not in themselves risk factors for HIV infection, correlate very strongly with risk. During 1998-2001, 502 cases of HIV/AIDS were reported: 84% of cases were males, 16% of cases were females and 69% of the cases were age 20-39. Highest age/sex specific rates of HIV/AIDS occurred among men age 30-39 (30.2 per 100,000), followed by men age 20-29 (12.9 per 100,000) and men age 40-49 (13.5 per 100,000). Highest age specific rates among women occurred in the age groups 20-29 (5.0 per 100,000) and 30-39 (2.8 per 100,000). Although rates and case totals were low among teenagers, the delay between infection and reporting means that some of the people reported as cases in the age group of 20-29 actually became infected while in the teenage years. The age distribution of reported HIV/AIDS has not changed appreciably during the last four years. The percentage of cases among females has increased somewhat.

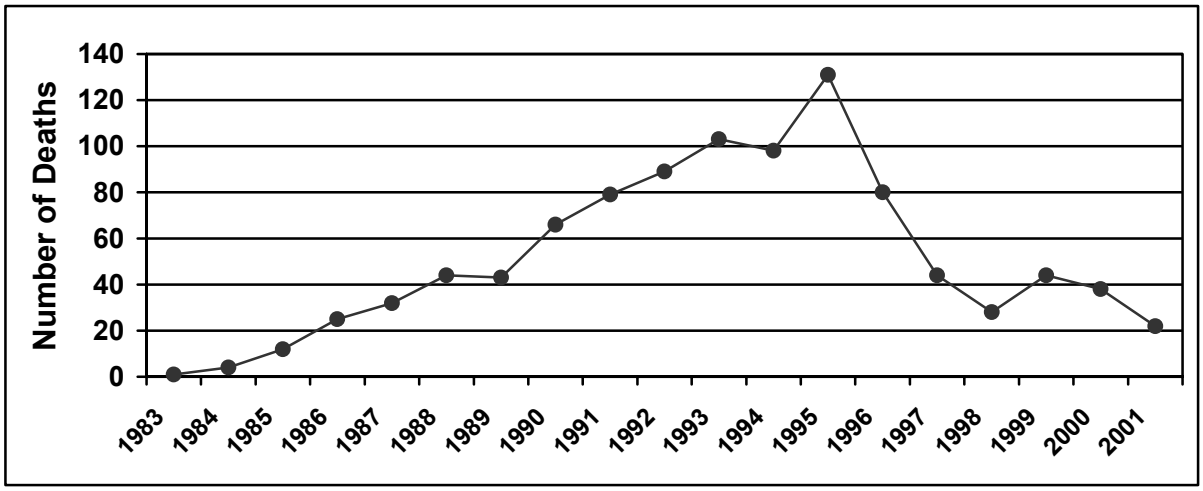
**Table 3.**
**Number of Cases of HIV/AIDS by Group and Sex, Utah 1998-2001.**




Source: Bureau of Communicable Disease Control, Utah Department of Health

The number of deaths from HIV/AIDS in Utah has decreased 83% from a peak of 131 deaths in 1995 to 22 deaths in 2001. This decline follows national trends and is largely the result of new, more effective antiretroviral treatment and improved laboratory monitoring. This trend has resulted in a large increase in the number of persons living longer in Utah with HIV/AIDS.

**Table 4.**
**Deaths From HIV/AIDS by Year, Utah 1983-2001.**




Source: Bureau of Communicable Disease Control, Utah Department of Health

Most HIV/AIDS cases continue to occur among men who have sex with men (MSM) (55%). The second largest risk is injecting drug use (IDU), which accounts for 17% of male cases and over 30% of female cases. Also, an additional 20-25% of female cases were due to sexual contact with IDU. Other heterosexual contact accounted for most of the remaining cases in both men and women.

**Table 5.**
**Combined HIV and AIDS Cases by Risk Group and Sex, Utah 1994-2001.**

**1994-1995**

| | MALE | | FEMALE | | TOTAL | |
|---|---|---|---|---|---|---|
| Risk Group | Cases | Percentages | Cases | Percentages | Cases | Percentages |
| MSM* | 219 | 67% | 0 | 0% | 219 | 61% |
| IDU** | 56 | 17% | 12 | 38% | 68 | 19% |
| MSM/IDU | 27 | 8% | 0 | 0% | 27 | 8% |
| Heterosexual with IDU | 3 | 1% | 8 | 25% | 11 | 3% |
| Hemophilia/Transfusion | 7 | 2% | 0 | 0% | 7 | 2% |
| Other Heterosexual Contact | 5 | 2% | 10 | 31% | 15 | 4% |
| Not Specified | 8 | 2% | 1 | 3% | 9 | 3% |
| Mother at Risk | 0 | 0% | 1 | 3% | 1 | 0% |
| TOTAL | 325 | 100% | 32 | 100% | 357 | 100% |

**1996-1997**

| | MALE | | FEMALE | | TOTAL | |
|---|---|---|---|---|---|---|
| Risk Group | Cases | Percentages | Cases | Percentages | Cases | Percentages |
| MSM* | 189 | 66% | 0 | 0% | 189 | 55% |
| IDU** | 57 | 20% | 22 | 42% | 79 | 23% |
| MSM/IDU | 22 | 8% | 0 | 0% | 22 | 6% |
| Heterosexual with IDU | 5 | 2% | 12 | 23% | 17 | 5% |
| Hemophilia/Transfusion | 1 | 0% | 2 | 4% | 3 | 1% |
| Other Heterosexual Contact | 5 | 2% | 13 | 25% | 18 | 5% |
| Not Specified | 9 | 3% | 3 | 6% | 12 | 4% |
| Mother at Risk | 0 | 0% | 1 | 2% | 1 | 0% |
| TOTAL | 288 | 100% | 53 | 100% | 341 | 100% |

**1998-1999**

| | MALE | | FEMALE | | TOTAL | |
|---|---|---|---|---|---|---|
| Risk Group | Cases | Percentages | Cases | Percentages | Cases | Percentages |
| MSM* | 155 | 69% | 0 | 0% | 155 | 59% |
| IDU** | 32 | 14% | 9 | 25% | 41 | 16% |
| MSM/IDU | 14 | 6% | 0 | 0% | 14 | 5% |
| Heterosexual with IDU | 5 | 2% | 9 | 25% | 14 | 5% |
| Hemophilia/Transfusion | 1 | 0% | 0 | 0% | 1 | 0% |
| Other Heterosexual Contact | 7 | 3% | 13 | 36% | 20 | 8% |
| Not Specified | 11 | 5% | 4 | 11% | 15 | 6% |
| Mother at Risk | 0 | 0% | 1 | 3% | 1 | 0% |
| TOTAL | 225 | 100% | 36 | 100% | 261 | 100% |

**2000-2001**

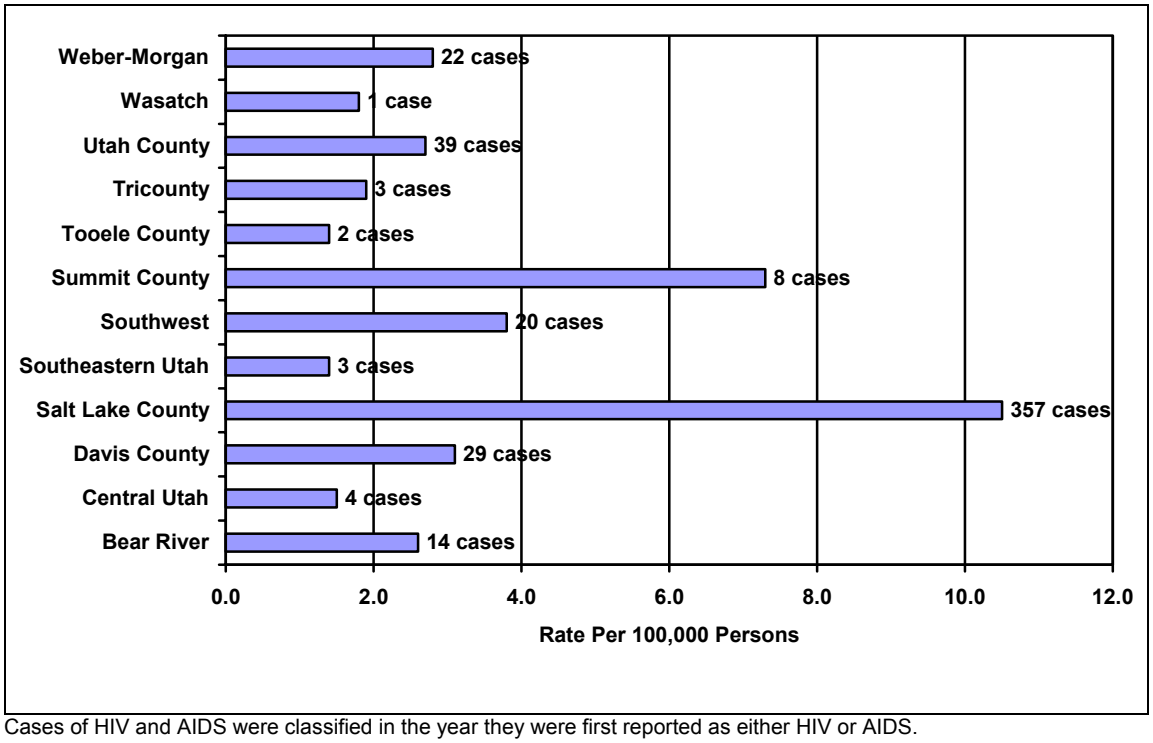
| | MALE | | FEMALE | | TOTAL | |
|---|---|---|---|---|---|---|
| Risk Group | Cases | Percentages | Cases | Percentages | Cases | Percentages |
| MSM* | 122 | 61% | 0 | 0% | 122 | 51% |
| IDU** | 22 | 11% | 6 | 14% | 28 | 12% |
| MSM/IDU | 14 | 7% | 0 | 0% | 14 | 6% |
| Heterosexual with IDU | 2 | 1% | 2 | 5% | 4 | 2% |
| Hemophilia/Transfusion | 4 | 2% | 2 | 5% | 6 | 2% |
| Other Heterosexual Contact | 6 | 3% | 12 | 29% | 18 | 7% |
| Not Specified | 27 | 14% | 19 | 45% | 46 | 19% |
| Mother at Risk | 2 | 1% | 1 | 2% | 2 | 1% |
| TOTAL | 199 | 100% | 42 | 100% | 241 | 100% |

* MSM – men who have sex with men
** IDU – injecting drug user
Mother at risk indicates an infant born to a mother with an established risk factor for HIV.
Cases of HIV and AIDS were classified in the year they were first reported as either HIV or AIDS.
Source: Bureau of Communicable Disease Control, Utah Department of Health

### *Demographic Distribution of HIV/AIDS in Utah*

In Utah and most of the U.S. HIV/AIDS has been disproportionately concentrated in urban areas. During 1998-2001, 71% of cases occurred in Salt Lake County, which also had the highest rate. Rates of reported HIV/AIDS decreased substantially between 1994-1997 and 1998-2001 in Salt Lake County and Weber/Morgan Health District, where rates were among the highest during the earlier period. Rates in health districts with few cases should be interpreted cautiously.

**Table 6.**
**Rates & Number of Cases of HIV/AIDS Reported by Local Health Districts, Utah 1998-2001.**




Cases of HIV and AIDS were classified in the year they were first reported as either HIV or AIDS.
Source: Bureau of Communicable Disease Control, Utah Department of Health

### *Projected Trends of the HIV/AIDS Epidemic in Utah*

Reported cases of HIV/AIDS in Utah have declined since 1993. Despite the declining incidence of new cases of HIV and AIDS, the number of people living with HIV disease has continued to increase. Part of that continuing increase is a result of improved antiretroviral treatment that has substantially delayed the onset of illness and death for many.

This trend represents an important public health success in preventing HIV disease, but prompts two concerns:

1) The number of people with HIV disease who are in need of treatment and prevention services, and who represent a risk of ongoing transmission, has continued to increase.
2) Every year, a new group of young people enters the period of life when behaviors placing them at risk for infection begin. Thus, despite the declining incidence of new HIV/AIDS cases, prevention remains even more important to protect these coming of age and at-risk persons.

In addition to the substantial and increasing number of people in need of prevention and treatment services, data suggests that there are a substantial number of infected people who may not know they are infected. Those people could benefit from treatment, and also represent a risk of ongoing transmission.

**Table 7.**
**Estimates of People Living With HIV or AIDS in Utah, 1998-1999.**

**Method 1** **Based on Proportion of AIDS Reported from Utah**

| | Reported AIDS Cases | | Proportion of All AIDS Cases Reported in Utah |
|---|---|---|---|
| | Utah | US | |
| **1998** | 150 | 51,882 | 0.289% |
| **1999** | 154 | 45,514 | 0.338% |
| **Average** | 304 | 97,396 | 0.312% |

Cases are for mid-year totals (July to June) from CDC surveillance report to yield comparable data

| Estimate for US | Low % | Medium % | High % |
|---|---|---|---|
| 800,000 | 2,313 | 2,497 | 2,707 |
| 850,000 | 2,457 | 2,653 | 2,876 |
| 900,000 | 2,602 | 2,809 | 3,045 |

| | |
|---|---|
| Best Estimate | 2,650 |
| Low | 2,300 |
| High | 3,050 |

**Method 2** **Based on Known Persons Adjusted for Sensitivity of Surveillance**

| | Number of cases alive at end of 1999 with: | | |
|---|---|---|---|
| | Pediatric | Adult | Total |
| **HIV** | 6 | 776 | 782 |
| **AIDS** | 7 | 1,015 | 1,022 |

| Estimated Sensitivity of Surveillance | Best | Low | High |
|---|---|---|---|
| **HIV** | 50% | 35% | 65% |
| **AIDS** | 85% | 80% | 90% |

| Estimates | Best | Low | High |
|---|---|---|---|
| **HIV** | 1,564 | 1,203 | 2,234 |
| **AIDS** | 1,202 | 1,136 | 1,278 |
| **TOTAL** | 2,766 | 2,339 | 3,512 |

**Table 7. (continued)**

**Method 3** **Based on Multiplier Developed by CDC**

| 1999 Reported AIDS Cases | 147 |
|---|---|

| | Multiplier | |
|---|---|---|
| **Low** | 15 | 2,205 |
| **Mid-Point** | 17.5 | 2,573 |
| **High** | 20 | 2,940 |

**Summary of Estimates**

| | Best | Low | High |
|---|---|---|---|
| **Method 1: % of AIDS in Utah** | 2,653 | 2,313 | 3,045 |
| **Method 2: Surveillance Sensitivity** | 2,766 | 2,339 | 3,512 |
| **Method 3: Multiplier Method** | 2,573 | 2,205 | 2,940 |
| **Average** | 2,664 | 2,286 | 3,166 |

Interpretation: The results using different methods are quite consistent. The data suggests a best estimate of 2,700 (range from 2,300 to 3,200).

### *Trends and Survival for Persons with AIDS Diagnosis in Utah*

Deaths due to HIV/AIDS have decreased 83% from a peak of 131 deaths in 1995 to 22 deaths in 2001. This decline mirrors national trends that are largely due to new and more effective antiretroviral treatment. This trend is expected to continue.

## II. Comprehensive Needs Assessment

### *Integration to other HRSA documents*

The Needs Assessment is a tool to determine client use, need, barrier, and gaps by service. It, and all other documents, is based on a foundation of a strong Epidemiological Profile that defines the prevalence[1] and incidence[2] of the affected community (People Living with HIV/AIDS – PLWHA).

This profile details these measures by numerous factors including gender, age, race/ethnicity, and exposure category.

A Comprehensive Strategic Plan defines the initiatives to be taken to reduce the incidence and prevalence of HIV/AIDS and links these to funded resources, whether through the Ryan White CARE Act or other funding sources. **It should be noted that the State of Utah is in the last year of a three-year Strategic Plan (2001-2003), with overlap that will occur as a new Comprehensive Strategic Plan incorporates the latest HRSA mandates. This Executive Summary of the Needs Assessment therefore depicts a future picture of investigation efforts that will inform those mandates.**

Efforts are planned for later in 2003 to also link the Continuum of Prevention with Treatment and Care. This will allow further reduction in progression of the disease, either through primary prevention of HIV or through secondary prevention of HIV progressing to AIDS.

### *Overview*

In the Spring and Summer of 2002, the Utah Department of Health conducted a needs assessment of People Living with HIV/AIDS (PLWH/A). The primary goal of this study was to identify client needs with regard to HIV/AIDS related services. Other goals were to identify disproportionate need between demographic groups and to identify barriers to service that PLWH/A might encounter.

[1] The development of a disease in a group over a period of time, rate of new cases.
[2] The number of existing cases of a disease or health condition in a population at some designated time

***Methodology***

The Needs Assessment for programs funded under the Ryan White Care Act was conducted from May through August 2002 by the Utah Department of Health. The actual survey occurred from July through mid-August (6 week period), preceded by two pilots (May-June). The survey was written at a 7th grade reading level and consisted of 58 questions (45 multiple choice items and 13 open-ended questions, for a total of 107 'variables').

Of the 951 surveys distributed, 277 surveys were returned. Four (4) surveys were excluded due to incomplete information, reducing the sample size to 273 or 17.9% of the estimated population living with HIV/AIDS (see Epidemiologic Profile).

Eleven (11) provider agencies returned these 277 surveys. The largest provider only returned 18/273 surveys (6.6%), which indicates that an even larger response rate than the impressive 17.9% participation of the affected community could have been achieved. Respondents reflect 17 of the 29 counties in Utah.

The majority of respondents were male, Caucasian and between the ages of 20-45. (80% v. 73% of estimated PLWH/A in this population.) A slight over-representation of Anglo MSM (7%) reflects the primary pool of the PLWH/A population and the geographic dominance of Salt Lake County in overall state population related to the majority of survey administration sites.

A target sample frame or distribution was derived from the Epidemiology Profile. Efforts were made to solicit participation in as close a manner as possible to this sample frame. This is important since the sampling methodology strives to mirror the affected community.

A sample frame defines a group of individuals who have been methodically selected from the population in the hope that studying this smaller group will reveal important information about the population. The population is the entire group of individuals that you wish to describe or about which you wish to generalize.

Conclusions derived from a client needs survey are deemed valid if the respondents reflect the PLWH/A community at large.

**Table 8.**
**Sample Frame -** ***Target Sample Distribution***
***2002 Utah HIV/AIDS Needs Assessment Survey***

| | Active | | Lost to Follow-up | | Total | | |
|---|---|---|---|---|---|---|---|
| | **Number** | **Percent** | **Number** | **Percent** | **Number** | **Percent** | **Sample Size** |
| **Gender** | | | | | | | |
| Male | 908 | 86.31% | 421 | 88.26% | 1,329 | 86.92% | 174 |
| Female | 144 | 13.69% | 56 | 11.74% | 200 | 13.08% | 26 |
| Total | 1,052 | 100.00% | 477 | 100.00% | 1,529 | 100.00% | 200 |
| **Age Group** | | | | | | | |
| 0-9 | 10 | 0.95% | 3 | 0.63% | 13 | 0.85% | 2 |
| 10-19 | 43 | 4.09% | 10 | 2.10% | 53 | 3.47% | 7 |
| 20-29 | 346 | 32.89% | 183 | 38.36% | 529 | 34.60% | 69 |
| 30-39 | 437 | 41.54% | 196 | 41.09% | 633 | 41.40% | 83 |
| 40-49 | 158 | 15.02% | 67 | 15.02% | 225 | 14.72% | 29 |
| 50+ | 59 | 5.51% | 18 | 5.51% | 76 | 4.97% | 10 |
| Total | 1,052 | 100.00% | 477 | 100.00% | 1,529 | 100.00% | 200 |
| **Race/Ethnicity** | | | | | | | |
| White | 813 | 77.28% | 331 | 69.39% | 1,144 | 74.82% | 150 |
| Black | 84 | 7.98% | 53 | 11.11% | 137 | 8.96% | 18 |
| Hispanic | 132 | 12.55% | 73 | 15.30% | 205 | 13.41% | 27 |
| Asian | 7 | 0.67% | 5 | 1.05% | 12 | 0.78% | 2 |
| Native American | 14 | 1.33% | 10 | 2.10% | 24 | 1.57% | 3 |
| Unknown | 2 | 0.19% | 5 | 1.05% | 7 | 0.46% | 1 |
| Total | 1,052 | 100.00% | 477 | 100.00% | 1,529 | 100.00% | 200 |
| **Risk Group** | | | | | | | |
| MSM | 636 | 60.46% | 252 | 52.83% | 888 | 58.08% | 116 |
| IDU | 155 | 14.73% | 104 | 21.80% | 259 | 16.94% | 34 |
| MSM/IDU | 76 | 7.22% | 40 | 8.39% | 116 | 7.59% | 15 |
| Heterosexual | 99 | 9.41% | 37 | 7.76% | 136 | 8.89% | 18 |
| Not Specified | 50 | 4.75% | 32 | 6.71% | 82 | 5.36% | 11 |
| Other | 36 | 3.42% | 12 | 2.52% | 48 | 3.14% | 6 |
| Total | 1,052 | 100.00% | 477 | 100.00% | 1,529 | 100.00% | 200 |

**Table 9.**
**Sample Frame - *Comparison of Target Sample Distribution to Response***
***2002 Utah HIV/AIDS Needs Assessment Survey***

| | Sample Size | % | Actual Response | % | Variance (Over/Under Represented) |
|---|---|---|---|---|---|
| **Gender** | | | | | |
| Male | 174 | 86.92% | 235 | 86.1% | (.82%) |
| Female | 26 | 13.08% | 37 | 13.6% | .52 |
| Transgender | - | | 1 | .4% | .4% |
| | 200 | 100.00% | 273 | | |
| **Age Group** | | | | | |
| 0-9 | 2 | 0.85% | - | - | (.85%) |
| 10-19 | 7 | 3.47% | - | - | (3.47%) |
| 20-29 | 69 | 34.60% | 27 | 9.9% | (24.7%) |
| 30-39 | 83 | 41.40% | 106 | 38.8% | (2.6%) |
| 40-49 | 29 | 14.72% | 102 | 37.4% | 22.68% |
| 50+ | 10 | 4.97% | 35 | 12.8% | 7.83% |
| Did not indicate | | | 3 | .1% | .1% |
| Total | 200 | 100.00% | 273 | | |
| **Race/Ethnicity** | | | | | |
| White | 150 | 74.82% | 207 | 75.8% | .98% |
| Black | 18 | 8.96% | 19 | 7% | (1.96%) |
| Hispanic | 27 | 13.41% | 28 | 10.3% | (3.11%) |
| Asian | 2 | 0.78% | 2 | 1% | .22% |
| Native American | 3 | 1.57% | 16 | 5.9% | 433% |
| Unknown | 1 | 0.46% | 1 | .5% | - |
| Total | 200 | 100.00% | 273 | | |
| **Risk Group** | | | | | |
| MSM | 116 | 58.08% | 167 | 61.2% | 3.12% |
| IDU | 34 | 16.94% | 38 | 13.9% | (3.04%) |
| MSM/IDU | 15 | 7.59% | 13 | 4.8% | (2.79%) |
| Heterosexual | 18 | 8.89% | 21 | 7.7% | (1.89%) |
| Not Specified | 11 | 5.36% | 27 | 9.9%% | 4.54% |
| Other | 6 | 3.14% | 7 | 2.5% | (.64%) |
| Total | 200 | 100.00% | 273 | | |

***Reflectiveness of Actual Survey Respondents: Target Sample Frame***

- Gender was the category most closely mirroring the target sample frame.
- Within age groups, there was a deficit at the lower end of the age spectrum. The age cohorts from 40-49 and 50+ were higher than anticipated.
- Within race/ethnicity, the group responding higher than expected was the Native American population, with the least match of Hispanics.
- MSM's were disproportionately over-represented, with IDU's and MSM/IDU under-represented. These latter groups are difficult to reach through traditional survey research, with goals for 2003 attempting to use qualitative research to reach them.

***Categories of Measurement***

Six (6) service categories were included on the survey. These include:

1) Medical services
2) Nutrition
3) Health Education
4) Mental Health
5) Drug and alcohol abuse
6) Other

Each service category was subdivided into subcategories, resulting in a total of 26 'individual services.'

**Table 10.**
**Categories of Measurement.**

| Service Category | Individual Service |
|---|---|
| Medical | Doctor Visits for HIV/AIDS<br>CD4 Count or Viral Load<br>Prenatal Care (Pregnancy)<br>Medical Care for a Child<br>Emergency Medical Care<br>HIV/AIDS Medications<br>Home Health Care<br>Help Paying for Health Insurance (COBRA or HIP) |
| Nutrition | Food Bank<br>Nutrition Education<br>Vitamins or Supplements |
| Health Education | Information about Treating HIV/AIDS<br>Information about how HIV is Spread<br>Help taking HIV/AIDS Medications/Side Effects |
| Mental Health | Psychiatrist/Mental Health Counseling<br>HIV/AIDS Support Group<br>Family Support Group |
| Drug/Alcohol Abuse | Alcohol or Drug Abuse Detoxification<br>Alcohol or Drug Counseling<br>Inpatient/Outpatient Drug Treatment<br>Self-Help Group for Drug Abusers |
| Other | Help with Housing<br>Legal Assistance<br>Vision Services<br>Dental Care<br>Case Management |

Respondents were asked to indicate need or use within the past year for each subcategory.

Demographic measures were included in the survey to identify disproportionate need among groups. The twelve (12) demographic measures included in the survey were:

1) Gender
2) Age
3) Rural/Urban
4) Significant Other
5) Children
6) Living Arrangement
7) Education
8) Language
9) Ethnicity
10) Sexual Orientation
11) Exposure Category
12) Income

The rural/urban measure was an indication of the area that the respondent lived in. Respondents were asked for their zip code with the survey classified as rural or urban based on this measure.

The children measure was an indication of whether the respondent had children living with them at least some of the time. The living arrangement queried whether or not the respondent had permanent or non-permanent housing.

In future Needs Assessments, additional stratification of the affected communities is desired with a subcategorization by HRSA's Care Groups with sub categorization by Severe Needs populations. These categories reflect both the over-riding goal of moving affected PLWH/A's into care and focus on historically underserved or unserved groups. It should be noted that in the State of Utah, only the MSM group has any statistical significance at this time. Data on these groups will be collected for future study.

In addition, studies will be conducted using the Utah Department of Health database comparing utilization to incidence to provide ongoing monitoring of any spike among these groups. One group that is not considered nationally significant which presents a treatment and care and prevention issue in the State of Utah is the Native American or American Indian population.

This will continue to be treated as an additional severe need group that is statistically significant in Utah.

**Table 11.**
**Suggested Future PLWH/A Stratification.**

| Care Group<br><br>(4 levels) | Severe Need Population<br><br>(9 populations) | Demographic Measures<br><br>(12 listed) | Service Category Use, Need, Barrier, Gap<br>(6 listed) | Individual Service Use, Need, Barrier, Gap (26 listed) |
|---|---|---|---|---|
| • In Care, In System<br>• In Care, Out of System<br>• Out of Care<br>• Never in Care | • AA MSM<br>• Anglo MSM<br>• Hispanic<br>• IDU<br>• Incarcerated/ Recently Released<br>• Native American<br>• Substance Abusers<br>• Women of Childbearing Age<br>• Youth | • Gender<br>• Age<br>• Rural/Urban<br>• Significant Other<br>• Children<br>• Living Arrangement<br>• Education<br>• Language<br>• Ethnicity<br>• Sexual Orientation<br>• Exposure Category<br>• Income | 1. Medical<br>2. Nutrition<br>3. Health Education<br>4. Mental Health<br>5. Drug & Alcohol Abuse<br>6. Other | (26 listed – Table 10) |

An estimate of the individuals by Care Group is given below using the Epidemiological Profile. The estimate of total PLWH/A's diagnosed in Utah is 1,529 (HARS: HIV/AIDS Reporting System).

**Table 12.**
**Care Groups**

| In Care, In System | In Care, Out of System | Out of Care* | Never in Care |
|---|---|---|---|
| 1,052 + 200 = 1,252 (81.88%) | | 277/1,529 = 18.1% | |

**In Care, Out of System** typically refers to PLWH/A's who have outmigrated from the area, seek or receive care from an alternate system (i.e. the military, private insurance) but were diagnosed through the public health system.

**Not in Care** is represented by **Out of Care*** – HRSA defined as six months not receiving primary medical care, and **Never in Care** – those diagnosed but choosing to never access care. The State of Utah compares favorably to the national percentage of 30% (Out of Care) and less than 5% (Never in Care), respectively. These latter two categories are difficult to reach using traditional survey methodology. They will be discussed in the Goals and Objectives as a Summer of 2003 initiative using qualitative research efforts.

In future data collection, there is a need to revise the current "Lost to Follow-up" cases by determining their disposition. Currently, a tremendous effort has tracked down almost half of

these cases through epidemiological investigation. Two of the nine (9) groups, Incarcerated/Recently Released and Substance Abusers, non-IDU were unable to be derived.

Three severe need groups (Anglo MSM, African-American MSM and Women of Childbearing Age) were imperfectly derived using the estimation logic displayed below.

The State of Utah doesn't currently enumerate PLWH/A by these severe need groups. In future studies, there is a plan to do so. Below is a calculation of these groups using current epidemiologic data based on 2001 figures. Not all severe need groups could be calculated.

**Table 13.**
**Severe Need Groups.**

| Severe Need Group | PLWH/A | Derived # | Calculation | EPI Reference, p. # |
|---|---|---|---|---|
| **MSM** | 888 | | | |
| Anglo MSM | | 622 | 70% MSM are White | Figure 25, p. 27 |
| African-American MSM | | 62 | 7% of MSM are Black | Figure 25, p. 27 |
| Hispanic | 205 | | | Table 10, p. 60 |
| Injection Drug User (IDU) | 259 | | | Table 10, p. 60 |
| Native Americans | 24 | | | Table 10, p. 60 |
| Women of Childbearing Age (ages 15-44) | | 140 | 225 x 62% (20-29, 30-39, 40-49) | Tables 8 , p. 58 and 10, p. 60 |
| Youth (ages 13-19) | 66 | | (0-0. 10-19) | Table 10, p. 60 |
| | | | | |
| *Incarcerated/Recently Released* | * | * | | |
| *Substance Abusers (not IDU)* | * | * | | |

** Could not determine at this time.*

While the significant groups are still the first four, these subpopulations of historically underserved or un-served PLWH/A bear ongoing data collection and comparison of epidemiological prevalence to incidence to ensure early intervention and/or preventive measures. Utah has maintained a profile similar to that of the beginnings of the epidemic, with an estimated 18% Out of Care.

Ongoing surveillance will attempt to be linked to preventive and treatment and care efforts. Restated by severe need group are the actual or derived count of People Living with HIV/AIDS as of December 31, 2001. The two groups that could not be calculated at this point require further data collection efforts. This is intended to occur with the 2003 modified RARE study.

**Table 14.**
**Severe Need Groups – Actual or Derived Number of PLWH/A In Utah.**

| Group | Actual or Derived # PLWH/A | % of Total |
|---|---|---|
| Anglo MSM | 622 | 41% |
| IDU | 259 | 17% |
| Hispanic | 205 | 13.4% |
| Women of Childbearing Age (ages 15-44) | 140 | 9.2% |
| Youth (ages 13-19) | 66 | 4.3% |
| AA MSM | 62 | 4.1% |
| Native Americans | 24 | 1.6% |
| *Incarcerated/ Recently Released* | * | * |
| *Substance Abusers (non-IDU)* | * | * |
| **Total** | | **1,529** |

In addition to these groups that are historically underserved, the high teen birth rate in Utah is correlated to a high HIV/STD risk. Ethnic groups of increasing concern include African immigrants, Asian Pacific Islanders, and the different subgroups of Native Americans. Native Americans vary significantly in risk behaviors if they are urban, on the reservation or move between these living situations. These groups will be targeted in the Summer modified RARE study.

***Needs Assessment Results***

Results are reported based on the responses of the valid 273 surveys.

**Table 15.**
**Most Needed Services.**

| Service Category | Individual Service | Respondents | IV. N | % of Total |
|---|---|---|---|---|
| Nutrition | Vitamins or Supplements | 70 | 273 | 25.6% |
| Other | Dental Care | 61 | 273 | 22.3% |
| Nutrition | Nutrition Education | 61 | 273 | 22.3% |
| Other | Legal Assistance | 50 | 273 | 18.3% |
| Other | Vision Services | 49 | 273 | 17.9% |
| Other | Help with Housing | 49 | 273 | 17.9% |
| Mental Health | HIV/AIDS Support Group | 48 | 273 | 17.6% |
| Nutrition | Food Bank | 44 | 273 | 16.1% |
| Mental Health | Psychiatrist Visits/Counseling | 37 | 273 | 13.6% |
| Medical | HIV/AIDS Medications | 36 | 273 | 13.2% |

**Table 16.**
**Most Used Services.**

| Service Category | Individual Service | Respondents | V. N | % of Total |
|---|---|---|---|---|
| Medical | Doctor Visits for HIV/AIDS | 229 | 273 | 83.9% |
| Medical | CD4 Count/Viral Load | 221 | 273 | 81.0% |
| Medical | HIV/AIDS Medications | 181 | 273 | 66.3% |
| Health Education | Information on Tx of HIV/AIDS | 146 | 273 | 53.5% |
| Health Education | Help Taking Meds and Dealing with Side Effects | 122 | 273 | 44.7% |
| Health Education | Info on Spread of HIV/AIDS | 122 | 273 | 44.7% |
| Nutrition | Food Bank | 119 | 273 | 43.6% |
| Other | Dental Care | 113 | 273 | 41.4% |
| Other | Case Management | 106 | 273 | 38.8% |
| Mental Health | Psychiatrist Visits/Counseling | 102 | 273 | 37.4% |

Some services appeared on both the “Most Needed” and “Most Used” lists. This indicates a correlation between the expressed high need and high use of the service. The four (4) services that appeared on both lists were:

1) Dental Care
2) Food Bank
3) Psychiatrist Visits/Mental Health Counseling
4) HIV/AIDS Medications

**Table 17.**
**Services Not Needed or Not Used.**

| Service Category | Individual Service | Respondents | N | % of Total |
|---|---|---|---|---|
| Medical | Prenatal Care | 261 | 273 | 95.6% |
| Medical | Medical Care for Children | 248 | 273 | 91.2% |
| Medical | Home Health Care | 246 | 273 | 90.1% |
| Drug Abuse | Alcohol/Drug Abuse Detox | 237 | 273 | 86.8% |
| Drug Abuse | Inpatient/Outpatient Drug Tx | 236 | 273 | 86.4% |
| Mental Health | Family Support Group | 230 | 273 | 84.2% |
| Drug Abuse | Alcohol/Drug Counseling | 229 | 273 | 83.9% |
| Drug Abuse | Self Help Group-Drug Abusers | 226 | 273 | 82.8% |
| Other | Legal Assistance | 194 | 273 | 71.1% |
| Mental Health | HIV/AIDS Support Group | 184 | 273 | 67.4% |

Some services appeared on both the “Most Needed” and “Not Needed or Not Used” lists. This indicates that there are disproportionate needs among these services, with some groups potentially having a high needs for this service and others having no or little need. The two services that appeared on both lists are:

1) Legal Assistance
2) HIV/AIDS Support Group

Listed barriers to services were those items that presented issues of access. By Service Category and Individual Service, these were:

**Table 18.**
**Listed Barriers to Service.**

| Medical, Nutrition, Health Education and Mental Health | Alcohol & Substance Abuse | Other Services |
|---|---|---|
| Transportation | Not knowing where to go | Cost |
| Cost | Transportation | Not knowing where to go |

Transportation and cost were the top two barriers to service encountered for medical services, nutrition services, health education services, and mental health services. Not knowing where to go and transportation were the top two barriers to service encountered for alcohol and substance abuse services. Cost and not knowing where to go were the top two barriers to service encountered for other services.

***Demographic Groups with Equal Need, Use, and No Need/Use***

Nine of the twelve (75%) demographic measures reported disproportionate need, use or lack of need/use for at least one service. These were gender, age, significant other, children, living arrangement, education, language, ethnicity and exposure category. Details of these findings by service are described below. Three demographic measures of the twelve (25%) reported equal levels of need, use, or lack of need/use. These were:

1) Rural/urban
2) Sexual orientation
3) Income level

1) Disproportionate Need/Use by "Gender"
   - Females did not indicate any need or use of the "Alcohol/Drug Counseling" service. A majority of males also expressed no need for this service. Males were more likely to have used this service as compared to females.
   - Both genders expressed a low need/use for the "Family Support Group" service. Females were more likely to express a need for this service when compared to males.

- In comparing males to females, males indicated more need for “Help with Housing” while females indicated more use of “Help with Housing.” Both genders indicated a higher use than need.

2) Disproportionate Need/Use by “Age”
   - Need for the “Information on How HIV/AIDS is Spread” service tends to decrease with age. As respondents got older they had less of a need for this service. The 30-39 age group represents the peak usage with usage decreasing with age.
   - The 20-29 and 40-49 age groups have a higher need for legal assistance. The 50 and over age group expressed no need at all for legal assistance.

3) Disproportionate Need/Use by “Significant Other”
   - Those with a significant other did not use the “HIV/AIDS Support Group” service although they expressed a need for the service. Those that did not have a significant other had approximately the same level of use and need for this service.
   - Those with a significant other are more likely to have no need/use for the “Case Management” service.
   - Those with no significant other were more likely to have received the “Dental Care” service than they were to have needed the service.

4) Disproportionate Need/Use by “Children”
   - Those with children were much more likely to have received “Medical Care for Children” than those without children. Those without children were much more likely to have expressed no need/use for this service.
   - Those without children were more likely to need “Prenatal Care” than those with children. Those with children were more likely to have received the care already.
   - Those who did not have children were twice as likely to have received the “Dental Care” service as compared to needing the service. Those with children seem to have equal need and use of the service.

5) Disproportionate Need/Use by “Living Arrangement”
   - Those in non-permanent housing reported approximately twice as much usage of the “Food Bank” service as those in permanent housing.
   - Those living in permanent housing have a much higher usage of the “Information on How HIV/AIDS is Spread” service than those living in non-permanent housing.

6) Disproportionate Need/Use by “Education”
   - As education level increases the usage of the “Food Bank” service decreases.

- There is a higher level of need and use of the "Alcohol/Drug Counseling" service in the early education levels. Need and use of this service decreases as education increases.
- Need for the "Legal Assistance" service increases with education until it peaks at those who have completed "some college." Need is still elevated for bachelor's degree and graduate degree respondents but not as high as the "some college" respondents.

7) Disproportionate Need/Use by "Language"
   - Those that spoke English were the only respondents indicating a need for the "Psychiatrist Visits/Mental Health Counseling" service. Those that spoke Spanish or other languages did not indicate any need for this service. Both English and Spanish speaking respondents reported having used the service.
   - Those that spoke English were the only respondents to indicate a need for the "Home Health Care" service. Those that spoke English were also the only respondents to indicate using this service.
   - Those that speak English expressed the greatest amount of need for "Legal Assistance."
   - Those that speak English expressed the greatest amount of need for "Prenatal Care."

8) Disproportionate Need/Use by "Ethnicity"
   - "White" respondents expressed a higher need for the "Psychiatrist Visits/Mental Health Counseling" service when compared to all other ethnic backgrounds.
   - "African American" respondents were more likely to have used the "HIV/AIDS Medications" service when compared to all other ethnic backgrounds.

9) Disproportionate Need/Use by "Exposure Category"
   - Those in the "IDU" exposure category were more likely to have used the "Self Help Group for Drug Abusers" service than any other group. "IDU" respondents were also expressed the highest level of need for this service.
   - Respondents in the "MSM" exposure category were more likely to have used and expressed a need for the "Home Health Care" service. Those in the "heterosexual" and "other" exposure categories did not indicate any need for this service at all.

## III. Inventory of Resources

For the creation of the Comprehensive HIV/AIDS Plan, it was necessary to examine the extent of the available resources for HIV services in Utah. Two types of HIV-related resources are described in this Section, fiscal and service. Also included is a description of the availability of other resources in the state.

### *Fiscal Resource Inventory*

Fiscal resources to the State of Utah include Ryan White Titles II, III, and V in addition to funding received through Housing Opportunities for Persons with AIDS (HOPWA).

**Table 19.**

**State of Utah 2003 Ryan White Title II Allocations.**

| | Ryan White Title II Base | ADAP | Emerging Communities* | Minority AIDS Initiative** | TOTAL |
|---|---|---|---|---|---|
| **Administrative Overhead** | $119,845.00 | $173,143.00 | $0.00 | $0.00 | $292,988.00 |
| **Planning & Evaluation** | $59,923.00 | $86,571.00 | $0.00 | $0.00 | $146,494.00 |
| **Quality Management** | $30,225.00 | $43,286.00 | $0.00 | $0.00 | $73,511.00 |
| **ADAP (AIDS Drug Assistance Program)** | $0.00 | $1,305,629.00 | $0.00 | $0.00 | $1,305,629.00 |
| **Health Insurance** | $478,774.00 | $72,803.00 | $0.00 | $0.00 | $551,577.00 |
| **Supportive Services** | $463,691.00 | $50,000.00 | $171,259.00 | $10,523.00 | $695,473.00 |
| **Supportive Services Administration** | $46,000.00 | $0.00 | $0.00 | $0.00 | $46,000.00 |
| **TOTAL** | $1,198,458.00 | $1,731,432.00 | $171,259.00 | $10,523.00 | **$3,111,672.00** |

* Emerging Communities: Supplemental funds to provide Title II services in the Salt Lake/Ogden area or the MSA (metropolitan statistical area).

** Minority AIDS Initiative: Funds provide educational and outreach programs to minority community-based organizations to increase the number of minorities participating in ADAP.

Compiled by: Jodie Pond
Ryan White Title II Grantee
Utah Department of Health
November 6, 2002

- **Administrative Overhead:** Funds, not to exceed 10% of amounts received, are used for administrative activities that include routine grant administration and monitoring activities.
- **Planning and Evaluation:** Funds, not to exceed 5% of amounts received, are used for planning and evaluation activities.
- **Quality Management:** Funds, not to exceed 5% of amounts received, are used for quality assurance activities.
- **ADAP:** Funds provide payment for approved pharmaceuticals and/or medications for persons with no other payment source.
- **Health Insurance:** Funds provide financial assistance for eligible individuals to maintain a continuity of health insurance or receive medical benefits under a health insurance program, including risk pools.
- **Supportive Services:** Funds provide supportive services throughout the state.
- **Supportive Services Administration:** Funds, not to exceed 10% of the supportive services amounts received, are used for supportive services administrative activities that include routine grant administration and monitoring activities.

**Table 20.**
**Ryan White Title II Support Services Budget, April 1, 2003 – March 31, 2004.**

| | Title II Base | ADAP | Emerging Communities | Minority AIDS Initiative | TOTAL |
|---|---|---|---|---|---|
| 1) Health Insurance | 478,774.00 | 72,803.00 | | | 551,577.00 |
| 2) ADAP | | 1,305,629.00 | | | 1,305,629.00 |
| SUPPORTIVE SERVICES | | | | | |
| 3) Ambulatory/Outpatient Medical Care | 40,000.00 | | 171,259.00 | | 211,259.00 |
| 4) Case Management | 225,000.00 | | | | 225,000.00 |
| 5) Related Housing Services | | | | | 0.00 |
| 6) Dental Care | 142,191.00 | | | | 142,191.00 |
| 7) Treatment Adherence | | | | | 0.00 |
| 8) Transportation | 5,000.00 | | | | 5,000.00 |
| 9) Short Term Housing (Motel) | 1,000.00 | | | | 1,000.00 |
| 10) Mental Health | 12,500.00 | | | | 12,500.00 |
| 11) Nutritional Counseling | 7,000.00 | | | | 7,000.00 |
| 12) Nutritional Supplements | | 50,000.00 | | | 50,000.00 |
| 13) Early Intervention | | | | | 0.00 |
| 14) Health Education/Risk Reduction | | | | | 0.00 |
| 15) Substance Abuse | 20,000.00 | | | | 20,000.00 |
| 16) Outreach Services (MAI) | | | | 10,523.00 | 10,523.00 |
| 17) Home Health Care | 5,000.00 | | | | 5,000.00 |
| 18) Other Supportive Services (Vision) | 2,000.00 | | | | 2,000.00 |
| 19) Legal Services | 2,000.00 | | | | 2,000.00 |
| 20) Emergency Services | 2,000.00 | | | | 2,000.00 |
| TOTAL | 942,465.00 | 1,428,432.00 | 171,259.00 | 10,523.00 | 2,552,679.00 |

Compiled by: Resource Allocation Subcommittee, HIV Treatment & Care Planning Committee
August, 2002

**Table 21.**
**State of Utah 2002 Ryan White Title III Allocations.**

| Line Item | FTEs | Primary Care | Program | Admin | TOTAL |
|---|---|---|---|---|---|
| ***Personnel*** | | | | | |
| Medical Director | 0.20 | | | | |
| Physician | 0.10 | | | | |
| Psychiatrist | 0.25 | | | | |
| Physician's Assistant | 0.20 | | | | |
| Quality Assurance/Medical Case Manager | 1.00 | | | | |
| New Physician | 0.64 | | | | |
| Eligibility/Patient Publication Specialist | 1.00 | | | | |
| Program Director | 0.35 | | | | |
| Nutritionist | 968hr | | | | |
| Pharmacist | 0.82 | | | | |
| Outreach Specialist | 1.00 | | | | |
| Data Entry/CQI Specialist | 0.15 | | | | |
| Immigrant Case Manager | 0.50 | | | | |
| **TOTAL - Personnel** | | **$242,899** | **$109,732** | **$45,317** | **$397,948** |
| ***Fringe Benefits*** (30.50%) | | $75,299 | $34,017 | $14,048 | $123,364 |
| **TOTAL - Fringe Benefits** | | **$75,299** | **$34,017** | **$14,048** | **$123,364** |
| ***Travel*** | | | | | |
| Clinical Conference | | $1,193 | | | $1,193 |
| Titles Conference (staff of three) | | | $2,386 | $1,193 | $3,579 |
| **TOTAL - Travel** | | **$1,193** | **$2,386** | **$1,193** | **$4,772** |
| ***Contractual*** | | | | | |
| Primary Care | | $8,800 | | | $8,800 |
| HIV Counseling & Testing | | $26,000 | | | $26,000 |
| Specialty Care | | $36,000 | | | $36,000 |
| Lab Tests (geno & phenotyping) | | $75,000 | | | $75,000 |
| **TOTAL - Contractual** | | **$145,800** | | | **$145,800** |
| ***Other*** | | | | | |
| Drugs & Medications | | $88,350 | | | $88,350 |
| **TOTAL - Other** | | **$88,350** | | | **$88,350** |
| ***Contractual Interpretations*** | | $10,000 | | | **$10,000** |
| **TOTAL-Interpretation** | | **$10,000** | | | **$10,000** |
| ***Supplies*** | | | | | |
| Program | | | $1,500 | | $1,500 |
| Administrative | | | | $1,500 | $1,500 |
| **TOTAL- Supplies** | | | **$1,500** | **$1,500** | **$3,000** |
| **GRAND TOTAL** | | **$563,541** | **$147,635** | **$62,058** | **$773,234** |

Compiled by:
Rose Logan
Ryan White Title III
University of Utah
Division of Infectious Diseases
January 9, 2003

**Table 22.**
**State of Utah 2000 Ryan White Part F Allocations.**

## Utah AIDS Education and Training Center (UAETC)
## Department of Family and Preventive Medicine
## University of Utah School of Medicine
## Budget Summary for 7/1/02 to 6/30/03

**Education Activities** **$97,561.**

Plan, implement, and evaluate approximately 65 HIV/AIDS education activities for more than 1,300 health care providers and health profession students in Utah, with an emphasis on physicians, physician's assistants, nurses, nurse practitioners, dentists, dental hygienists, pharmacists, and mental health providers, particularly providers in rural Utah. Pay for, and distribute to health care providers educational materials on HIV/AIDS prevention, early identification, and treatment. Travel to education activities in rural Utah. Participate in community planning and other HIV-related community activities.

**Administrative Coordination:** **$41,328.75**

Organize education activities, attend weekly UAETC staff meeting, and attend quarterly regional management team meetings.

**Minority AIDS Initiative:** **$10,000.**

Subcontract with Utah Community Based Organization to provide HIV "Train the Trainer" education to at least 50 Latino Community HIV Outreach Workers.

**Indirect Costs @ 8%:** **$11,111.**

Paid to the University of Utah to support the UAETC project.

**Total Budget:** **$149,979.**

Compiled by:
Michael Rigdon, Ph.D.
Associate Professor and Coordinator,
Utah AIDS Education and Training Center
December 31, 2003

**Table 23.**
**State of Utah 2002-2003 Housing Opportunities for People with AIDS (HOPWA) Allocations.**

**Utah State FY 2002-2003 (7/1/02 – 6/30/03) HOPWA Program**

| AGENCY | $ ALLOCATED | FUNDING ID USED FOR |
|---|---|---|
| DCED (Department of Community and Economic Development) | $ 1,770.00 | State Administration (3%) |
| St. George Housing Authority Southern Utah-rural | $ 23,219.00 | Long term and emergency/5PLWH/A |
| (for Southwestern rural Utah, 3rd year of program expires 6/30/03) | | |
| Salt Lake Community Action Program | $ 30,000.00 | Rent/Mort/Dep/Util/Emerg/20PLWH/A |
| (One year ends 6/30/03, for Southern and Eastern rural Utah) | | |
| Kenyon Consulting, Inc. | $ 7,500.00 | Coord/Resource Identification |
| (One year ends 6/30/03) | | |
| Housing Authority of the County of Salt Lake | $ 77,000.00 | Long term rental assistance |
| (4th year ends 6/30/03) | | |
| Catholic Community Services – Ogden | $ 87,500.00 | Emergency/short term rental assist. |
| (for northern rural Utah, 4th year ends 6/30/03) | | |
| **TOTAL** | **$199,989.00** | |

**Housing & Urban Development (HUD) Shelter Plus Care Utah**
**State HIV/AIDS Housing Programs**

| AGENCY | $ ALLOCATED | FUNDING ID USED FOR |
|---|---|---|
| Housing Authority Salt Lake City | $201,800.00 | 4-2BR Units/PBRA/Expires 2005 |
| Housing Authority Salt Lake City | $373,248.00 | 17 TBRA/10 years/Expires 2007 |
| Catholic Community Services - Ogden | $158,055.00 | 4-1BR Units/PBRA/Expires 2003 |

**PLWH/A**—Persons Living With HIV/AIDS
**PBRA**—Project Based Rental Assistance
**TBRA**—Tenant Based Rental Assistance

Compiled by:
Sherman Roquiero
Utah Department of Community
and Economic Development
December 02, 2002

***Service Resource Inventory***

*Development of the Service Resource Directory*

In March, 2000, HIV Treatment and Care Program staff revised a service resource directory originally compiled by the University of Utah's Social Research Institute at the Graduate School of Social Work. The format of this new directory focused specifically on HIV Treatment and Care Services, including Title II Providers, with information about HIV-related services and non-HIV related services that can be accessed by PLWH/A.

*Distribution of the Service Resource Directory*

The new HIV/AIDS Treatment/Care Resource Directory first became available to service providers for distribution to clients/patients and caregivers in July 2000. It has since been updated during the fall of 2002 and is now available to service providers. In addition, anyone calling the Utah Department of Health, Bureau of Communicable Disease Control toll free number (800) 537-1046 can request a copy.

The directory is updated annually, and service providers should call the Utah Department of Health Bureau of HIV/AIDS toll free number with changes as they occur.

The resource directory can be easily photocopied by service providers as needed, so that each client/patient receives copies with current information about available services.

The resource directory is currently in the process of being added to our website (**http://www.health.state.ut.us/els/hivaids**) and should be available by late spring 2003. This will enable providers and consumers to access the most current resource information available.

*Implications for Service Delivery*

Three out of the five objectives in Goal #5 (see Goals and Objectives in Section B, page 55) emphasize increasing services to individuals. One of the ways this will be accomplished is to provide more information about available services to HIV/AIDS service providers so they can, in turn, distribute that information accurately to clients and patients.

***Availability of Other Resources***

Other resources available to cover health care costs of eligible individuals and families with HIV disease include the State of Utah Medicaid Plan and the State of Utah Children's Health Insurance Program (CHIP).

State of Utah Medicaid Plan

To be eligible for Medicaid, an applicant must first qualify for a category of Medicaid established by federal regulations. Each category has requirements concerning citizenship, resources (assets), and monthly income. Medicaid eligibility is determined each month for each individual. Each person applying for Medicaid must qualify under one of the following categories:

- Age 65 or older
- Legally disabled or blind
- Pregnant women
- Child under age 18
- Parent or caretaker of a child under age 19
- Women with breast or cervical cancer

Full Medicaid benefits are available only to U.S. citizens and legal residents. Federal regulations limit an individual's resources to $2,000. For a family, the limit starts at $3,000. Federal regulations also require the state to set monthly income standards which vary based on the category of Medicaid.

A person who does not qualify for a category of Medicaid is considered for the Primary Care Network (PCN) Program. The PCN Program serves individuals age 19 and above with incomes under 150% of the federal poverty level who are not otherwise eligible for Medicaid through the State Plan and who are eligible only through a waiver of federal Medicaid requirements approved by the federal Centers for Medicare and Medicaid Services.

An applicant who has monthly income which is more than the monthly income standard, but less than the amount needed to pay his or her medical bills, may be considered for the Medicaid Medically Needy program. The program is also referred to as the "spenddown" program. To qualify for Medicaid coverage of medical bills, the person agrees to "spend down" his or her monthly income to the Medicaid income standard. The person may choose to either pay "excess" monthly income to the state or to pay a portion of his or her monthly medical bills directly to the medical provider.

A person who is not a citizen or a legal resident may qualify for Emergency Services Program. This program limits benefits to emergency medical services only.

For more information about the Utah Medicaid Program, call the toll-free Medicaid Information Hotline: 1-800-662-9651 or visit their Internet site: www.health.state.ut.us/medicaid.

### State of Utah Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) is a medical assistance program for children who do not have other health insurance and who meet the eligibility criteria. A child may qualify when three conditions are met:

- The child is 18 years or younger
- Family income is below 200% of the federal poverty level (FPL) and the child is not eligible for Medicaid.
- There is no other insurance plan available, either from employer or individual.

For more information about the CHIP Program, call the CHIP Hotline: 1-888-222-2542 or visit the CHIP Internet site: www.health.state.ut.us/chip.

## IV. Continuum of Care and Service Priorities

***Process for Establishing a Client-Centered Continuum of Care***

The continuum of care in Utah is not consistent throughout the state. The majority of Utahns living with HIV/AIDS reside along the Wasatch Front (Davis, Weber, Salt Lake, and Utah counties). These four counties account for 77% of the population of the state, and 89% of all reported cases of HIV/AIDS.

**Table 24.**
**Location of Diagnosis for Combined HIV & AIDS Cases by Local Health District, Four-Year Period, Utah 1998-2001.**

| Local Health District | Cases* | Population | Percent of Cases | Rate** |
|---|---|---|---|---|
| Bear River | 14 | 528,378 | 2.8% | 2.6 |
| Central Utah | 4 | 261,864 | 0.8% | 1.5 |
| Davis County | 29 | 949,657 | 5.8% | 3.1 |
| Salt Lake Valley | 357 | 3,389,146 | 71.1% | 10.5 |
| Southeastern Utah | 3 | 220,443 | 0.6% | 1.4 |
| Southwest | 20 | 524,367 | 4.0% | 3.8 |
| Summit County | 8 | 108,883 | 1.6% | 7.3 |
| Tooele County | 2 | 143,507 | 0.4% | 1.4 |
| Tricounty | 3 | 160,899 | 0.6% | 1.9 |
| Utah County | 39 | 1,423,864 | 7.8% | 2.7 |
| Wasatch | 1 | 55,674 | 0.2% | 1.8 |
| Weber-Morgan | 22 | 774,303 | 4.4% | 2.8 |
| **Totals** | **502** | **8,540,985** | **100%** | **5.9** |

* 4-year total cases.
** Average annual rate per 100,000 persons.
Cases of HIV and AIDS were classified in the year they were first reported either as HIV or AIDS. Population totals are for four years. That is, they are the sum of the population in each year. The average population for this time period can be calculated by dividing these totals by four years.
Source: Bureau of Communicable Disease Control, Utah Department of Health

Those individuals living with HIV/AIDS and residing outside the Wasatch Front have greater difficulty finding and receiving quality care for their illness.

In September, 2000, members of the HIV Treatment and Care Planning Committee and members of the community met to discuss the statewide needs in Utah. The rural uniqueness of the state was a crosscutting issue affecting several of the identified needs. In rural Utah, there seems to be a common attitude of “We don’t have HIV in our community.” PLWH in rural Utah can feel

isolated and reluctant to seek appropriate care. HIV-related services affected by this rural uniqueness include:

Primary Medical Care:

There is a need to increase access to adequate medical care in rural areas (outside the Wasatch Front).

Dental Care:

Adequate dental care in rural areas is an ongoing need.

Housing:

There is a lack of available and affordable housing in rural areas.

Health Communication Technology:

There is a rising need for access to, and funding of, new technology (i.e., telehealth) to aid in care, education and evaluation in rural areas.

Competent/Knowledgeable Rural Providers

Not only are we lacking rural providers in many service areas, but there is a shortage of competent and knowledgeable providers in those areas.

Case Management Coordination

Case management services need improved coordination, especially outside of Salt Lake City metropolitan area.

Stigma

Fear of disclosure (HIV status, sexual orientation and drug use), especially in smaller communities, can greatly influence people living with HIV disease from seeking treatment and care.

Additionally, providers may be reluctant to provide treatment and care to HIV/AIDS patients for fear of becoming known as the “AIDS” doctor, especially in smaller communities.

Transportation

Many people living in rural Utah travel long distances to receive their health care. There is adequate daytime public transportation available within urban areas but no public transportation is available from the rural areas.

***Process for Establishing Service Priorities***

The HIV Treatment and Care Planning Committee spent the first four months of 2002 obtaining background information and educating themselves in HIV/AIDS issues, trends and available resources in Utah.

In June 2002 the Committee began work on prioritizing the supportive service categories for Utah. The task was of great importance considering the substantial need of services and limited resources available. The larger Committee broke into four small groups and the members discussed priority setting perspectives and the diverse needs of consumers. Each small group was assigned one of the following criteria categories:

- Essential to health/well-being (Weight = 30%)
- Keeps people in medical care or directs them to care (Weight = 35%)
- Meets a documented need or fills an identified service gap - based on epidemiological profile, needs assessment, and other sources of information. (Weight = 25%)
- Consumer preference or demand - including preferences for particular service interventions for particular populations, especially those with severe need. (Weight = 10%)

A Priority Setting Score Sheet (Table 15) was passed out to the small groups. With the use of a Priority Setting Scoring Key (Table 16), the members were asked to evaluate each service category.

**Table 25.**
**Priority Setting Score Sheet.**

| Service Category | Please Circle Score for Each Priority Setting Category | | | | Data Sources |
|---|---|---|---|---|---|
| ***Health Care Services*** | *Keeps consumers in medical care/directs them to care* ***Weight = 35*** | *Essential to health/well-being* ***Weight = 30*** | *Meets an identified need or service gap* ***Weight = 25*** | *Consumer preference* ***Weight = 10*** | |
| (1) Ambulatory/Outpatient Medical Care | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (2) ADAP | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (3) Health Insurance | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (4) Home Health Care | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (5) Oral Health (Dental Care) | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (6) Mental Health Services | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (7) Nutritional Counseling | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (8) Substance Abuse Therapy | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (9) Treatment Adherence Services | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| ***Support Services*** | | | | | |
| (10) Case Management | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (11) Early Intervention Services | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (12) Nutritional Supplements | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (13) Health Education/Risk Reduction | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (14) Housing Services (Motel Stays) | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (15) Legal Services | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (16) Outreach Services | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (17) Related Housing Services | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (18) Transportation Services | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |
| (19) Other Support Services (Vision) | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 | |

**Table 26.**
**Priority Setting – Scoring Key.**

| Criteria | Score | Definition |
|---|---|---|
| 1 – Keeps people in medical care or directs them to care.<br><br>WEIGHT = 35% | 0 | Service does nothing to help keep people in medical care or direct them to care. |
| | 1 | |
| | 2 | |
| | 3 | |
| | 4 | |
| | 5 | Service plays a major role in keeping people in medical care/directing them to care. |
| 2 – Essential to health/well-being.<br><br>WEIGHT = 30% | 0 | No relationship between service and consumer's health/well-being. |
| | 1 | |
| | 2 | |
| | 3 | |
| | 4 | |
| | 5 | Without service, consumer's health/well-being would be seriously affected |
| 3 – Meets a documented need or fills an identified service gap (based on epi profile, needs assessment, and other sources of information).<br><br>WEIGHT = 25% | 0 | Service does not meet an identified service gap. |
| | 1 | |
| | 2 | |
| | 3 | |
| | 4 | |
| | 5 | Service meets an identified service gap. |
| 4 – Consumer preferences or demand (including preferences for particular service interventions for particular populations, especially those with severe need).<br><br>WEIGHT = 10% | 0 | Consumers do not feel the service is needed in the community. |
| | 1 | |
| | 2 | |
| | 3 | |
| | 4 | |
| | 5 | Consumers feel the service is strongly needed in the community. |

At this point, Priority Setting Score Sheets were completed by each small group and returned to staff. The purpose of this ranking is to ensure that the most important service categories are funded first in the event that resources are not enough to cover all service categories. The Executive Committee weighed the priorities using the ranking sheet filled out by committee members and came up with the following results:

**Table 27.**
**Priority Setting 2003-2004 (Ranked & Weighted).**

| Service Category | Keeps People in Care | | | | | Essential to Health | | | | | Meets a Service Gap | | | | | Consumer Preferences | | | | | Total Score | | | | | RANK | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Group 1 | Group 2 | Group 3 | Group 4 | Average Score | Group 1 | Group 2 | Group 3 | Group 4 | Average Score | Group 1 | Group 2 | Group 3 | Group 4 | Average Score | Group 1 | Group 2 | Group 3 | Group 4 | Average Score | Group 1 | Group 2 | Group 3 | Group 4 | Average Score | Group 1 | Group 2 | Group 3 | Group 4 | Overall |
| ***Health Care Services*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (1) Ambulatory/Outpatient Medical Care | 5 | 5 | 5 | 4 | 33 | 5 | 5 | 5 | 5 | 30 | 5 | 5 | 5 | 3 | 23 | 3 | 4 | 5 | 5 | 9 | 96 | 98 | 100 | 83 | 94 | 4 | 2 | 1 | 5 | 3 |
| (2) ADAP | 5 | 5 | 5 | 4 | 33 | 5 | 5 | 5 | 5 | 30 | 5 | 5 | 5 | 4 | 24 | 5 | 4 | 5 | 5 | 10 | 100 | 98 | 100 | 88 | 97 | 1 | 2 | 1 | 2 | 2 |
| (3) Health Insurance | 5 | 5 | 5 | 5 | 35 | 5 | 5 | 5 | 3 | 27 | 5 | 5 | 5 | 5 | 25 | 5 | 5 | 5 | 5 | 10 | 100 | 100 | 100 | 88 | 97 | 1 | 1 | 1 | 2 | 1 |
| (4) Home Health Care | 3 | 4 | 0 | 3 | 18 | 4 | 4 | 3 | 4 | 23 | 4 | 3 | 0 | 3 | 13 | 1 | 3 | 0 | 3 | 4 | 67 | 73 | 18 | 66 | 56 | 14 | 11 | 19 | 11 | 17 |
| (5) Oral Health (Dental Care) | 2 | 4 | 1 | 2 | 16 | 4 | 4 | 5 | 5 | 27 | 4 | 5 | 5 | 5 | 24 | 5 | 4 | 5 | 5 | 10 | 68 | 85 | 72 | 79 | 76 | 13 | 7 | 13 | 6 | 8 |
| (6) Mental Health Services | 2 | 4 | 4 | 2 | 21 | 5 | 5 | 3 | 5 | 27 | 5 | 4 | 3 | 4 | 20 | 2 | 3 | 1 | 4 | 5 | 73 | 84 | 63 | 72 | 73 | 10 | 8 | 14 | 10 | 11 |
| (7) Nutrtional Counseling | 2 | 4 | 5 | 4 | 26 | 5 | 3 | 3 | 5 | 24 | 4 | 3 | 4 | 5 | 20 | 3 | 2 | 3 | 3 | 6 | 70 | 65 | 79 | 89 | 76 | 12 | 13 | 12 | 1 | 9 |
| (8) Substance Abuse Therapy | 1 | 4 | 2 | 3 | 18 | 5 | 4 | 4 | 5 | 27 | 3 | 3 | 4 | 4 | 18 | 1 | 3 | 2 | 2 | 4 | 54 | 73 | 62 | 75 | 66 | 18 | 11 | 15 | 8 | 14 |
| (9) Treatment Adherence Therapy | 2 | 5 | 5 | 3 | 26 | 5 | 5 | 5 | 3 | 27 | 3 | 4 | 5 | 3 | 19 | 1 | 3 | 4 | 2 | 5 | 61 | 91 | 98 | 58 | 77 | 15 | 5 | 8 | 12 | 7 |
| ***Support Services*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (10) Case Management | 5 | 5 | 5 | 5 | 35 | 5 | 5 | 5 | 2 | 26 | 5 | 4 | 5 | 5 | 24 | 4 | 4 | 5 | 3 | 8 | 98 | 93 | 100 | 78 | 92 | 3 | 4 | 1 | 7 | 4 |
| (11) Early Intervention Services (EIS) | 5 | 4 | 5 | 2 | 28 | 5 | 4 | 5 | 1 | 23 | 5 | 2 | 5 | 2 | 18 | 3 | 1 | 5 | 1 | 5 | 96 | 64 | 100 | 32 | 73 | 4 | 15 | 1 | 18 | 11 |
| (12) Food Bank/Meal Delivery/Nutritional Supplements | 2 | 3 | 0 | 0 | 9 | 4 | 4 | 4 | 4 | 24 | 5 | 2 | 5 | * | 20 | 4 | 4 | 5 | 3 | 8 | 71 | 63 | 59 | 40 | 61 | 11 | 16 | 16 | 17 | 16 |
| (13) Health Education/Risk Reduction | 3 | 3 | 5 | 1 | 21 | 5 | 2 | 5 | 3 | 23 | 5 | 3 | 5 | 3 | 20 | 4 | 2 | 5 | 1 | 6 | 84 | 52 | 100 | 42 | 70 | 6 | 17 | 1 | 16 | 13 |
| (14) Housing Services (short-term motel stays) | 3 | 5 | 5 | 0 | 23 | 5 | 4 | 5 | 4 | 27 | 5 | 3 | 3 | 4 | 19 | 3 | 3 | 2 | 5 | 7 | 82 | 80 | 84 | 54 | 75 | 7 | 9 | 10 | 14 | 10 |
| (15) Legal Services (incl. Perm. Planning & Child Welfare) | 1 | 3 | 0 | 0 | 7 | 3 | 1 | 4 | 0 | 12 | 4 | 2 | 4 | 3 | 16 | 4 | 2 | 4 | 2 | 6 | 53 | 41 | 52 | 19 | 41 | 19 | 19 | 17 | 19 | 19 |
| (16) Outreach Services | 3 | 4 | 5 | 1 | 23 | 3 | 3 | 5 | 2 | 20 | 3 | 3 | 5 | 4 | 19 | 2 | 2 | 3 | 2 | 5 | 58 | 65 | 96 | 43 | 66 | 17 | 13 | 9 | 15 | 15 |
| (17) Related Housing Services (e.g. assisted living) | 4 | 4 | 5 | 4 | 30 | 4 | 4 | 5 | 5 | 27 | 4 | 4 | 3 | 5 | 20 | 4 | 4 | 2 | 2 | 6 | 80 | 80 | 84 | 87 | 83 | 9 | 9 | 10 | 4 | 5 |
| (18) Transportation | 3 | 5 | 5 | 4 | 30 | 3 | 5 | 5 | 2 | 23 | 3 | 3 | 5 | 5 | 20 | 3 | 3 | 5 | 4 | 8 | 60 | 86 | 100 | 73 | 80 | 16 | 6 | 1 | 9 | 6 |
| (19) Other Support Services (incl. Vision, etc…) | 4 | 2 | 1 | 3 | 18 | 3 | 3 | 1 | 1 | 12 | 5 | 2 | 1 | 5 | 16 | 5 | 2 | 1 | 3 | 6 | 81 | 46 | 20 | 58 | 51 | 8 | 18 | 18 | 12 | 18 |

The results were then presented to the entire HIV Treatment and Care Planning Committee. After group discussion and some voted changes, the Committee identified and prioritized services as follows:

**Table 28.**
**2003-2004 Priority Setting (Final List).**

| |
|---|
| *1. Health Insurance* |
| *2. ADAP* |
| *3. Ambulatory/Outpatient Medical Care* |
| *4. Case Management* |
| *5. Related Housing Services* |
| *6. Dental Care* |
| *7. Treatment Adherence* |
| *8. Transportation* |
| *9. Short –Term Housing* |
| *10. Mental Health* |
| *11. Nutritional Counseling* |
| *12. Food Bank/Home Delivered Meals/Food Vouchers* |
| *13. Early Intervention* |
| *14. Health Education/Risk Reduction* |
| *15. Substance Abuse* |
| *16. Outreach Services* |
| *17. Home Health Care* |
| *18. Other Support Services (i.e. vision)* |
| *19. Legal Services* |
| 20. *Emergency Services* |

***Process for Establishing Resource Allocation***

In July 2002 the Resource Allocation Subcommittee met to allocate funds to the Ryan White Title II Service Categories. Each member of this subcommittee was asked to declare any conflict of interest they might have. Using the Prioritized Service Category List (Table 28) set by the HIV Treatment & Care Planning Committee, the subcommittee worked through each of the following five worksheets (in working order):

1. Service Priorities Comparison (Table 29)
2. Services and Costs (Table 30)
3. Unmet Service Needs and Cost Estimates (Table 31)
4. Estimated Service Needs (Table 32)
5. Priorities and Funding Allocations (Table 33)

**Table 29.**
**Service Priorities Comparison.**

| Service Category | Priority for 2003-04 | Priority for 2002-03 | % of Current Year's Allocation 2002-2003 | Amt of Current Year's Allocation 2002-2003 |
|---|---|---|---|---|
| Health Insurance | 1 | 6 | 14.25% | $405,605.00 |
| (ADAP) | | | 3.51% | $100,000.00 |
| ADAP | 2 | 1 | 50.60% | $1,439,881.00 |
| Ambulatory/Outpatient Care | 3 | 1 | 9.27% | $263,846.00 |
| Case Management | 4 | 5 | 7.91% | $225,000.00 |
| Related Housing Services | 5 | 16 | 0.00% | $0.00 |
| Dental Care | 6 | 10 | 8.26% | $235,000.00 |
| Treatment Adherence | 7 | 8 | 0.00% | $0.00 |
| Transportation | 8 | 8 | 0.18% | $5,000.00 |
| Short-term Housing | 9 | 13 | 0.00% | $0.00 |
| Mental Health Therapy | 10 | 11 | 0.70% | $20,000.00 |
| Nutritional Counseling | 11 | 4 | 0.00% | $0.00 |
| Food Bank/Meal Delivery/Food Vouchers | 12 | 13 | 3.78% | $107,499.00 |
| Early Intervention | 13 | N/A | 0.00% | $0.00 |
| Health Education/Risk Reduction | 14 | 6 | 0.00% | $0.00 |
| Substance Abuse | 15 | 3 | 0.70% | $20,000.00 |
| Outreach Services | 16 | 18 | 0.37% | $10,523.00 |
| Home Health Care | 17 | 13 | 0.18% | $5,000.00 |
| Other Support Services (i.e. vision) | 18 | 16 | 0.11% | $3,000.00 |
| Legal Services | 19 | 12 | 0.18% | $5,000.00 |
| Emergency Services | 20 | 19 | 0.00% | $0.00 |
| TOTAL | | | 100.00% | $2,845,354.00 |

**Table 30.**
**Services and Costs.**

| Service Category | Number of Clients Served 2001-2002 | Average Cost per Client per Year | Funding for 2001-2002 | Unspent Funds |
|---|---|---|---|---|
| Health Insurance | | | | |
| *Cobra* | 50 | | | |
| *HIP* | 134 | | | |
| ADAP | 217 | | | |
| Ambulatory/Outpatient Care | | | | |
| *Laboratory Tests* | 254 | | | |
| Case Management | | | | |
| Related Housing Services | | | | |
| Dental Care | 214 | | | |
| Treatment Adherence | | | | |
| Transportation | | | | |
| *Gas Card* | 17 | | | |
| *Other* | 91 | | | |
| Short-term Housing (Hotel/Motel) | 12 | | | |
| Mental Health Therapy | | | | |
| *MH Counseling/Group* | 16 | | | |
| *MH Counseling/Individual* | 25 | | | |
| Nutritional Counseling | | | | |
| *Medical Nutritional Supplements* | 147 | | | |
| *Vitamin Supplements* | 297 | | | |
| Food Bank/Meal Delivery/Food Vouchers | | | | |
| *Food Vouchers* | 287 | | | |
| Early Intervention | | | | |
| Health Education/Risk Reduction | | | | |
| Substance Abuse | | | | |
| *Methadone Treatment* | 8 | | | |
| *Outpatient SA Counseling/Group* | 2 | | | |
| *Outpatient SA Counseling/Individual* | 8 | | | |
| *Residential Substance Abuse* | 10 | | | |
| Outreach Services | | | | |
| Home Health Care | 16 | | | |
| Other Support Services (i.e. vision) | 48 | | | |
| Legal Services | 12 | | | |
| Emergency Services | 14 | | | |
| Assessment & Referral | 13 | | | |

- Did funds for certain services run out before the end of the year?
- Were funds reallocated because of under-expenditure or low demand?

**Table 31.**
**Unmet Service Needs and Cost Estimates.**

| Unmet Service Need | Estimated Number of Persons Needing but Not Receiving Service | Estimated Unit Costs for Next Year | Estimated Additional Costs of Meeting Need (Above Current Funding) | Reason |
|---|---|---|---|---|
| Dental | | | | Increase Cap |
| Emergency Funds | | | | Ran out of money |
| Housing | | | | Need vouchers for rural areas |
| Mental Health Therapy | | | | Need Ryan White Title II provider in Provo area; Support group |
| Legal Services | | | | |

**Table 32.**
**Service Priorities Comparison.**

| Service Category | Total Need per Year (Number of Clients) | Average Cost per Client per Year | Total Funds Required to Meet Need | Other Available Funds | Unmet Need or Service Gap |
|---|---|---|---|---|---|
| (1) Ambulatory/Outpatient Care | | | | | |
| *Laboratory Testing* | Units: 402 | | $80,000 | RWTIII: $75,012 | |
| *Emerging Communities* | | | $165,141 | | |
| *Physician* | | | $30,000 | RWTIII Total: $773,234 | |
| (3) ADAP | | | | | |
| *UDOH* | 175 | $12,000 | $2,100,000 | | |
| *Clinic 1A* | | | $75,000 | RWTIII: $88,350 | |
| (11) Substance Abuse Treatment | | | $46,000 | | |
| (9) Nutritional Counseling | 500-700 | | $33,000 | RWTIII: $34,063 | |
| (15) Case Management | | | | | |
| *Clinic 1A* | | | $149,464 | RWTIII: $113,608 | |
| *CHAMP* | | | $155,250 | | |
| *UAF* | | | $41,745 | | |
| (21) Health Education/Risk Reduction | | | | | |
| *UAETC* | | | | $71,575 | |
| (4) Health Insurance | 135 | | $500,000 | | |
| (12) HIV/AIDS Tx Adherence | | | $55,000 | RWTIII: $54,434 | |
| (28) Transportation | | | $7,000 | | |
| (2) Dental Care | | | $150,000 | | |
| (8) Mental Health Therapy | | | $35,000 | | |
| (24) Legal Services | | | $5,500 | | |
| (20) Food Bank/Meal Delivery | | | | | |
| *Supplements* | 250 | | $110,000 | | |
| *Food Certificates* | 275-300 | | $150,000 | | |
| *Vitamins* | 1,070 units | | $7,500 | | |
| *UAF Food Bank* | | | $10,000 | | |
| (22) Housing Assistance | | | $4,000 | HOPWA: SLC-$380,000 | |
| (5) Home Health Care | 20 | | $10,747 | | |
| (23) Housing Related Services | | | $0 | | |
| (29) Other Support Services | | | | | |
| *Vision* | | | $3,000 | | |
| (25) Outreach (CBC) | | | $9,064 | | |
| (19) Emergency Financial Assistance | | | $6,500 | | |
| (6) Hospice Services | | | $0 | | |
| (10) Rehabilitation Care | | | $0 | | |
| (17) Counseling-Other | | | $0 | | |
| (27) Referral | | | $0 | | |
| (14) Buddy/Companion Services | | | $0 | | |
| (16) Client Advocacy | | | $0 | | |
| (18) Day or Respite Care | | | $0 | | |
| (26) Permanency Planning | | | $0 | | |
| (7) In-Patient Personnel Costs | | | $0 | | |
| (13) Adoption/Foster Care | | | $0 | | |

* Numbers in () in the first column reference the service category definitions distributed by HRSA.

**Table 33.**
**Priorities and Funding Allocations, April 1, 2003 - March 31, 2004.**

| Service Category | Priority | Percent of Funds | Dollars |
|---|---|---|---|
| (1) Ambulatory/Outpatient Care | 1 | | |
| (3) ADAP | 1 | | |
| (11) Substance Abuse Treatment | 3 | | |
| (9) Nutritional Counseling | 4 | | |
| (15) Case Management | 5 | | |
| (21) Health Education/Risk Reduction | 6 | | |
| (4) Health Insurance | 6 | | |
| (12) HIV/AIDS Tx Adherence | 8 | | |
| (28) Transportation | 8 | | |
| (2) Dental Care | 10 | | |
| (8) Mental Health Therapy | 11 | | |
| (24) Legal Services | 12 | | |
| (20) Food Bank/Meal Delivery | 13 | | |
| (22) Housing Assistance | 13 | | |
| (5) Home Health Care | 13 | | |
| (23) Housing Related Services | 16 | | |
| (29) Other Support Services | 16 | | |
| (25) Outreach (CBC) | 18 | | |
| (19) Emergency Financial Assistance | 19 | | |
| (6) Hospice Services | 20 | | |
| (10) Rehabilitation Care | 21 | | |
| (17) Counseling-Other | 21 | | |
| (27) Referral | 23 | | |
| (14) Buddy/Companion Services | 24 | | |
| (16) Client Advocacy | 25 | | |
| (18) Day or Respite Care | 26 | | |
| (26) Permanency Planning | 27 | | |
| (7) In-Patient Personnel Costs | 28 | | |
| (13) Adoption/Foster Care | 29 | | |

* Numbers in () in the first column reference the service category definitions distributed by HRSA.

Once the information from the five tables was worked through, the subcommittee went over each service category and using the dollar amounts used for each category from last year and the dollar amounts requested for the 2003-2004 funding year, allocations and cuts emerged. These allocations were presented to the entire HIV Treatment & Care Planning Committee in September 2002. The Committee voted to accept the proposed Supportive Services budget for 2003-2004 (see Table 20).

***Gap Analysis***

During the spring of 2001 a Gap Analysis was compiled for PLWH/A in Utah. Based on a review of the epidemiological profile, the Statewide Coordinated Statement of Need (SCSN), Needs Assessment, and the availability of local resources and assessments of local needs, awareness of the following HIV service gaps emerged:

**Women/Infants/Children/Youth**

- Gender specific health care and mental health services
- Location, transportation and hours of operation issues to be address through "mobile services"
- Services after 5 p.m. for those who work.
- Recruit staff to better represent special populations (i.e. more women, especially Hispanic and African American women)

**PLWH/A not in care**

**Adolescent/Teenager** – The low number of cases in this population could indicate a gap in counseling/testing available to this age group.

- Anonymous testing in high schools of teens might indicate a higher incidence of HIV infection than is presently reported.
- Requiring testing for athletic physicals or extra curricular activities.
- Need comprehensive testing of sexually active teens.
- Age categories need to be more discerning. (i.e. 10-14 and 15-19)
- Link services/privileges such as drivers licenses and anonymous testing

**Transgendered** – This community is tightly knit and most needs are generally being met.

- Specialized medical services, such as hormones.
- Nutrition counseling and outreach services targeted to this population.

**Homeless** – The highly transient nature of this community makes assessing its gaps difficult.

- Housing service represent greatest need.
- Consistent outreach programs which address substance abuse, nutritional counseling, and sanitation issues.

**Transitional** – This population represents people who were accessing services and then experienced an interruption in utilization due to a change in circumstances.

- Access to services and knowledge concerning services.
- Transportation from rural to urban areas.

**American Indian** – Unique cultural and heritage aspects of this population and its geographical dispersal make gap analysis difficult.

- Access to reservations and transportation issues.
- Cultural competency training for outreach workers and service providers.
- Access to housing services, substance abuse treatment, and nutritional counseling.
- Adequate opportunities for anonymous testing.

**Lost in System** – Unclear what gaps exist with these individuals.

- Finding a way to get these individuals into Case Management services could supply adequate opportunities for utilization of all other support services.

**Communities of Color**

- Services are available, but lack of providers and educational materials specific to each cultural need.
- Many cultures do not understand and/or trust the healthcare system as a whole. Information needs to come from indigenous sources, i.e. respected and trusted sources within specific communities.
- Minority populations in Utah are increasing, but the healthcare system has changed little to cover the emerging needs of this growing population.
- The needs to break down language/vocabulary barriers and also increase translations available for all services is becoming increasingly significant.
- There is a lack of providers, educational materials, and conveniently located services available to meet the needs for Utah's ethnic populations.

**Rural**

- There is a mobile clinic to Washington County every other month, but not in other rural areas of the state.
- There are scattered community-based organizations that offer minimal services to those infected with HIV disease in rural areas of Utah.
- Some Dental and Substance Abuse services are available, but other services are lacking.
- Many clients do not feel comfortable accessing services in their own communities; therefore, they resort to traveling to the closest urban area (Wasatch Front) for medical and/or social services.
- Not only are we lacking rural providers in most service areas, but there is a shortage of competent and knowledgeable providers in those rural areas.

**General Population of PLWH/A**

- Adherence to treatment programs.

- Consistent interagency knowledge concerning substance abuse programs and the processes for drug treatment.
- Adequate services (like culturally appropriate mental health and support groups) that help people live with HIV disease.
- Social marketing efforts about services to providers/clients.
- Ongoing education about the role and benefits of case management services.

## V. Barriers to Care

This section describes the issues and barriers to care as perceived by HIV Treatment and Care Planning Committee members and community affiliates.

In September, 2000, the Statewide Coordinated Statement of Need Committee, made up of members from the Treatment and Care Planning Committee and individuals from the community, met to identify the issues and barriers to effective HIV/AIDS services. The participants included both service providers and people who utilize HIV/AIDS services. Barriers to care were identified by the following categories: case management coordination, changes in eligibility criteria, economic issues, stigma and cultural sensitivity.

### *Case Management Coordination*

Case Management services need improved coordination, especially outside of the Salt Lake City metropolitan area. For clients, the case management system can be a confusing structure (sometimes causing duplication of services). More focus needs to be placed on people who are in crisis or not familiar with the system. Outreach needs to be expanded to those who do not have access to resources, or may not be in care.

### *Changes in Eligibility Criteria*

Multiple HIV-related services with different eligibility requirements create difficulties for PLWH/A who are unfamiliar with changing program criteria.

### *Economic Issues*

Generally limited financial resources greatly impair the ability of PLWH/A to access required services. Additionally level Federal funding will limit access to services needed by PLWH/A and will prevent those services from further expansion.

The financial burden associated with the treatment of HIV disease is continually growing. Expensive high-tech medical tests, up-to-the-minute costly medications, and inadequate health insurance coverage impair what services a PLWH/A may be able to access. The adverse change in socioeconomic status a PLWH/A faces can be an emotional detriment to wellness as well as a financial dilemma.

***Stigma***

Fear of disclosure (HIV status, sexual orientation, and/or substance use/abuse) especially in smaller communities can greatly and negatively influence PLWH/A from seeking treatment and care. Additionally providers may be reluctant to provide treatment and care to HIV/AIDS patients for fear of becoming known as the "AIDS" doctor, especially in smaller communities.

***Cultural Sensitivity***

Cultural diversity within the ideal community demands cultural diversity within the ideal health care system. Unfortunately, the community is changing faster than the health care system can meet the need. Thus, PLWH/A from other cultures have difficulty relating to the health care system as is and many distrust the system altogether. The need to break down language barriers and to increase translation/interpretation availability for all services is becoming increasingly significant.

Salt Lake City has recently been designated as a refugee center for HIV infected refugees and Salt Lake City-based resettlement organizations have been approved to assist the HIV infected refugees. Approximately 60 HIV infected refugees will be re-located to Salt Lake City (15 each year between 2000 and 2003). This presents an emerging need for culturally and linguistically appropriate care integration with the present refugee resettlement program, targeted prevention, and improved surveillance. There are great variations in perceptions of the health care system by different cultural and immigrant/migrant communities.

## VI. Other Major Service Delivery Issues

### *Insurance Issues*

Under insured health insurance coverage or no health coverage at all continues to be a financial burden for people with HIV disease. Co-pays, deductibles, and Medicaid spend downs are far too costly and can greatly impair the ability and willingness of PLWH/A to access medically required services. Because many PLWH/A are unable to work or are employed for short intermittent periods of time, it is difficult to keep or obtain complete health coverage.

### *Continuation of Life*

With new advances in medical treatment and drug therapies, PLWH/A are living longer. Many are returning to work and would benefit from vocational rehabilitation services before re-entering the work force. Additionally, as life expectancies with HIV disease are lengthened, so is the extended need for supportive services. Services should address the continuation of life issues as well as related psychological needs and quality of life issues.

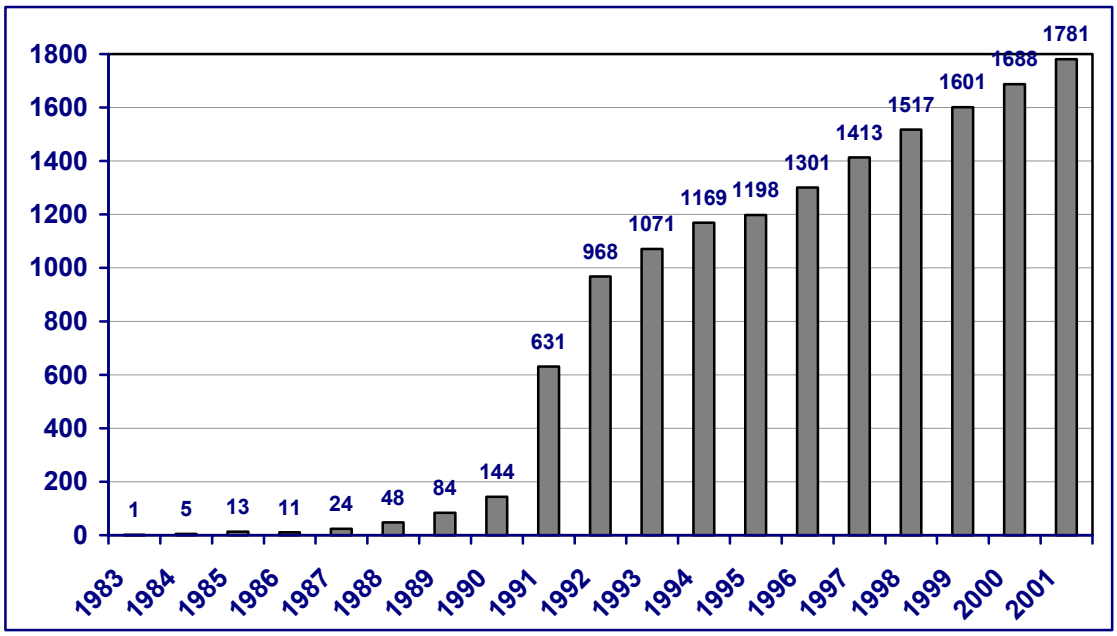
# SECTION B WHERE WE ARE GOING AND HOW WE WILL GET THERE

## I. Utah's Response to the Epidemic

### *Trend History*

Most of our understanding of the occurrence of HIV/AIDS comes from case surveillance. In Utah, AIDS has been a reportable disease since 1983 and HIV has been reportable since 1989. Reported cases of HIV and AIDS in Utah have declined since 1993. This is a trend that has also occurred nationally. Although there has been a recent declining incidence of new cases of HIV and AIDS, the number of people living with HIV disease has continued to increase. Part of that continuing increase survival is a result of improved drug therapies that have substantially delayed the onset of illness and death. The decrease in deaths due to HIV/AIDS has resulted primarily from the dramatically improved efficacy of newer antiretroviral medications and availability of viral load testing.

**Table 34.**
**Number of Persons Reported in Utah with HIV or AIDS Believed to be Alive (Cumulative) at End of Each Year, Utah 1983-2001.**




Each total is the number of people who have been reported with either HIV or AIDS prior to the end of that year and who were believed to be alive and a resident of Utah. Each annual total is cumulative and totals from different years should not be added. These data include about 405 persons who were reported in Utah, but subsequently have moved out of state and exclude about 96 persons known to have moved into Utah after being reported in another state.
Note: totals are subject to change as notice of death is not consistently reported/received within the same year of death.
Source: Bureau of Communicable Disease Control, Utah Department of Health

The increase in the number of people living with HIV disease has greatly focused our efforts toward treatment and care, HIV prevention interventions, community participation and resource utilization.

***Ryan White CARE Act***

On August 18, 1990, Congress passed Public Law 101-381 entitled The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (the Act). The purpose of the Act was to provide "emergency assistance to localities…disproportionately affected by the Human Immunodeficiency Virus (HIV) epidemic and to make financial assistance available to states and other public and private nonprofit entities to provide for the development, organization, coordination and operation of more effective and cost efficient systems for the delivery of essential services to individuals and families with HIV disease."

The Act was created to establish services for patients with Acquired Immunodeficiency Syndrome (AIDS) or HIV who would otherwise have no access to health care. It was meant to provide emergency relief funding to communities with the highest number of reported AIDS cases.

The Act has four titles. The bulk of the funds fall under Titles I and II. Utah does not qualify for Title I funds, as they provide emergency relief grants to metropolitan areas disproportionately affected by the HIV epidemic. Title II provides formula grants to states and territories to improve the quality, availability, and organization of health care and support services for individuals and families with HIV disease. Title III provides grants for local Early Intervention Treatment, and Part F makes available grants for community-based organizations to provide services to people living with HIV disease and training for health care professionals.

Utah has been granted Title II funds every year since the inception of the Ryan White CARE Act legislation. The following Ryan White Title II amounts have been allocated to Utah:

**Table 35.**
**Ryan White Title II Allocations, Utah 1991-2003.**

| *Year* | *Base Award* | *ADAP Earmark** | *Emerging Communities*** | *Minority AIDS Initiative**** | *Total Award* |
|---|---|---|---|---|---|
| 2003 | $1,198,458 | $1,731,432 | $171,259 | $10,523 | **$3,111,672** |
| 2003 amounts are based on level funding expectations. Exact amounts will be available in Spring 2003. | | | | | |
| 2002 | $1,198,458 | $1,731,432 | $171,259 | $10,523 | **$3,111,672** |
| 2001 | $1,075,695 | $1,548,076 | $165,141 | $10,071 | **$2,788,913** |
| 2000 | $1,057,785 | $1,368,976 | - | - | **$2,426,761** |
| 1999 | $946,495 | $1,136,619 | - | - | **$2,083,114** |
| 1998 | $858,827 | $684,104 | - | - | **$1,542,931** |
| 1997 | $852,251 | $399,273 | - | - | **$1,251,524** |
| 1996 | $691,928 | $118,115 | - | - | **$810,043** |
| 1995 | $428,266 | - | - | - | **$428,266** |
| 1994 | $511,096 | - | - | - | **$511,096** |
| 1993 | $304,258 | - | - | - | **$304,258** |
| 1992 | $329,083 | - | - | - | **$329,083** |
| 1991 | $146,661 | - | - | - | **$146,661** |

* Prior to 1996, ADAP Earmark did not exist.

** Prior to 2001, Utah did not qualify for Emerging Communities Funds.

*** Prior to 2001, Utah did not qualify for Minority AIDS Initiative Funds.

Currently Ryan White Title II funding is being used for the AIDS Drug Assistance Program (ADAP), the Home Health Care Program, the Health Insurance Continuation Program (HICP), and the Supportive Services Program.

# II. Overview of the HIV Treatment and Care Planning Committee, and Description of the Planning Process

### *The Need for a Comprehensive HIV/AIDS Plan in Utah*

In 1990, the Utah HIV Coordination of Care Council was established. This Council served as the entity responsible for Consortia activities. Through a lead agency the Consortium was responsible for planning and implementing Title II Supportive Services. In 1999, the Consortium underwent significant changes. The Utah Department of Health, with technical assistance provided by HRSA, came to the conclusion that the Consortium's planning activities were too limited. It was decided that a larger planning body should be established to look at one hundred percent of the Title II funds rather than the twenty five percent in the supportive services only the Consortium was then overseeing. At that time, the Utah HIV Treatment and Care Planning Committee was established.

### *Development of a Coordinated HIV Planning Effort*

The Utah Department of Health first proposed an integrated treatment/care and prevention education planning group in September, 1999. The goal of this integration was to improve and enhance participation and resource utilization in HIV prevention and care. This effort would help forge linkages across the disciplines of HIV treatment and care and prevention education, ultimately improving access to primary medical care and prevention services.

The Utah HIV Planning Advisory Council met for the first time in February 2000. The meeting was successful with a rich discussion occurring between members of the prevention and treatment and care communities. Throughout this process the focus has been on three key issues:

1. Keeping a clear vision of the need for a statewide integrated planning process. As more people are living with HIV disease in Utah, the need to wisely steward our resources is critical.
2. This change is being done to promote increased consumer and community participation in the greater, statewide context of HIV planning. The needs of the entire state must be presented in all discussions.
3. Everyone involved in the prevention and care continuum will benefit from the collective input or experience of prevention and treatment and care partners working together.

***Purpose of the Statewide HIV Planning Advisory Council***

The purpose of the Utah HIV Planning Advisory Council (The Council) is to oversee the development of the annual Comprehensive HIV/AIDS Plan. The Comprehensive HIV/AIDS Plan serves as the guiding document for policy makers, health planners and community representatives. The Council also serves as a mechanism to promote integration of HIV Treatment and Care services with HIV Education and Prevention activities. Strong emphasis is placed on actualizing the prevention-care-prevention continuum through joint meetings, shared membership and collaborative projects. The Council has approximately 65 members. The Council members are individuals who serve on the HIV Treatment and Care Planning Committee and/or the HIV Prevention Community Planning Committee.

**Table 36.**
**Organizational Chart**

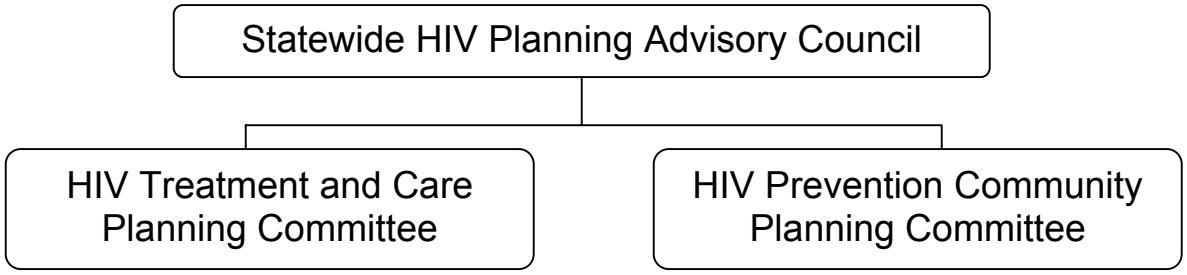
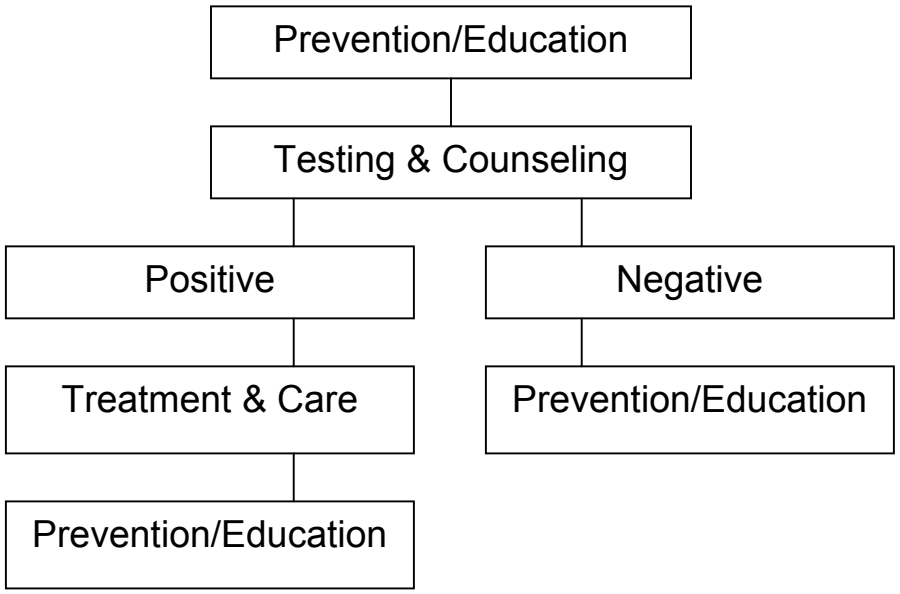



**Table 37.**
**The Continuum of HIV Services.**



***Statewide HIV Planning Advisory Council Operations, Workload and Timeline***

The Statewide HIV Planning Advisory Council began with an orientation meeting in November 2001 for the upcoming 2002 year. The Council met twice between the orientation meeting and the fall of 2002. Additionally, the Treatment and Care Planning Committee and the Prevention Community Planning Committee met separately a total of six times each. Each committee has individual subcommittees and is working toward combining efforts in the future. A new Ad Hoc subcommittee was formed in July 2002. The Prevention for Positives subcommittee is a formal standing subgroup between the two Committees. The members convened twice in 2002 and will continue to meet quarterly. When asked what prevention for positives means to them, members of this subcommittee responded:

- Self-esteem
- Healthy decisions
- Assimilating HIV into daily life so PLWH/A can move along a spectrum of self-esteem and healthy lifestyles
- Requires creativity and innovation
- Would like to see the focus as overall health in general, not just HIV prevention – need to look at more of a holistic health approach.

Currently, it is the responsibility of the Treatment and Care Planning Committee to oversee the creation of the Comprehensive HIV/AIDS Plan.

The staff of the Utah Department of Health, Bureau of Communicable Disease Control serves as administrative and clerical support to the Statewide HIV Planning Advisory Council. The professional staff of the Utah Department of Health, Bureau of Communicable Disease Control provided the epidemiologic, demographic, needs assessment and Ryan White Title II grant information that was used in creating the Comprehensive HIV/AIDS Plan.

The Council established a timeline during which work was to be accomplished. Their goal was to have the Comprehensive HIV/AIDS Plan in place by January, 2003.

**Table 38.**
**2002 Timeline – HIV Treatment and Care Planning Committee & HIV Prevention Community Planning Committee.**

| | November 2001 | December 2002 | January 2002 |
|---|---|---|---|
| **Prevention Community Planning** | * New committee orientation<br>* Introduce Timeline for 2002<br>* Review Ground Rules<br>* Review Charter<br>* Present and discuss CPC purpose/process (9 steps)<br>* Educate members on each committees planning process | **Combined Statewide HIV Planning Advisory Council** *<br>Winter Celebration<br>* Approve Charter<br>* Form task groups | * Select co-chair elect<br>* Presentation on behavioral theories<br>* Review of research-based HIV prevention programs and interventions<br>* Ethnic contract presentations |
| **Treatment & Care Planning** | * New committee orientation<br>* Introduce Timeline for 2002<br>* Review Ground Rules<br>* Vote on Bylaws<br>* Educate members on each committees planning process | **Combined Statewide HIV Planning Advisory Council** *<br>Winter Celebration | * Comprehensive Plan (draft) presentation<br>* Elect co-chairs<br>* Form subcommittees |

| | February 2002 | March 2002 | April 2002 |
|---|---|---|---|
| **Prevention Community Planning** | * Review of counseling and testing data<br>* At-risk and rural contract presentations | **Combined Statewide HIV Planning Advisory Council**<br>* Epidemiological Profile presentation<br>* Review info gathering methods<br>* Task group presentations<br>* Task groups – begin goals & objectives for 2003<br>* Midpoint evaluations | * Task groups – continue goals & objectives for 2003 |
| **Treatment & Care Planning** | No meeting due to 2002 Olympics and difficulty traveling in town during that time. | **Combined Statewide HIV Planning Advisory Council**<br>* Epidemiological Profile presentation<br>* Counseling & Testing Data presentation<br>* Final Comprehensive Plan presentation | * Review timeline (full committee & subcommittee)<br>* Elect subcommittee chairs<br>* AAR (Annual Administrative Report – User Data Report)<br>* Education of service categories (Part 1) |

| | May 2002 | June 2002 | July 2002 |
|---|---|---|---|
| **Prevention Community Planning** | * Task groups – present recommended goals & objectives for 2003 | * Continue each task groups presentation of recommended goals & objectives for 2003 | * Budget review by CPC subcommittee |
| **Treatment & Care Planning** | * Education of service categories (Part 2)<br>* Subcommittee updates<br>* Update on Medicaid changes<br>* Midpoint evaluations | * Subcommittee updates<br>* Review Priority Setting process<br>* Review Legislative Guidance<br>* Priority Setting (Part 1) | * Review Bylaws Draft<br>* Review Draft of Policy & Procedure document<br>* Priority Setting (Part 2) |

| | August 2002 | September 2002 | October 2002 |
|---|---|---|---|
| **Prevention Community Planning** | * Present budget recommendations<br>* Complete letter of concurrence<br>* Evaluate CPC process | No meeting | * Open nomination period for new member applications<br>* Membership Committee selects new and returning members. |
| **Treatment & Care Planning** | No Meeting<br>* Resource Allocation Subcommittee meets to prepare budget recommendations | * Review Goals & Objectives Progress Report<br>* Present Goals & Objectives for 2003-2004<br>* Review Resource Allocation recommendations for 2003 budget; vote on budget | * Open nomination period for new member applications<br>* Membership Committee selects new and returning members. |

## III. Treatment and Care Planning Committee's Vision and Guiding Principles

***Shared Vision for the Title II Comprehensive HIV/AIDS Plan***

During the first year of the HIV Treatment and Care Planning Committee, the members were charged with creating a vision statement that would become the guiding principle for the creation of the Comprehensive HIV/AIDS Plan. The Committee determined that all PLWH/A in Utah should be the focus of their vision. The vision for the Title II Comprehensive HIV/AIDS Care and Services Plan is to:

> ***Ensure the accessibility of quality treatment and care in a manner that ensures dignity for people affected by HIV disease.***

***Guiding Principles for the Committee Designing the Comprehensive HIV/AIDS Plan***

These are the guiding principles that led the HIV Treatment and Care Planning Committee members throughout the planning process as they established the criteria for creating this plan.

***As a committee, we will strive to create a plan that will commit resources to:***

- ***Serving the under-served***

  All persons living with HIV/AIDS will be offered access to care that is appropriate and broad in scope throughout all stages of their illness.

- ***Ensuring access to treatment and supportive care***

  The coordination of care will meet the needs of, and be accessible to, all populations with HIV/AIDS, all communities, all cultures, and in all geographic locations of Utah.

- ***Adapting to changes in the health care system***

  The delivery system will be flexible, innovative, and efficient in accordance with community-defined standards of care.

- ***Documenting outcomes/results and evaluation***

  The Comprehensive HIV/AIDS Plan will be sustained and supported through community-based collaboration and public/private partnerships with technical assistance to assess client needs, develop and manage cost-effective programs, and evaluate services delivered.

## IV. Goals and Objectives for 2002 through 2003

The goal of the Ryan White Title II program in the State of Utah is to provide for the development, organization, coordination and operation of a more cost effective and efficient system for the delivery of essential services to individuals and families with HIV disease.

**AIDS Drug Assistance Program:**

**Goal:** To ensure that medications are available to persons living with HIV disease.

- Objective: On an annual basis, 225 unduplicated clients will be served through the AIDS Drug Assistance Program.

**Home Health Care Program:**

**Goal:** To ensure that home and community based care services are available in order to reduce hospitalizations for persons living with HIV disease.

- Objective: On an annual basis, 20 unduplicated clients will be served through the Home Health Care Program.

**Health Insurance Continuation Program:**

**Goal:** To ensure that Health Insurance Continuation services are available to provide health insurance coverage to persons living with HIV disease.

- Objective: On an annual basis, 150 unduplicated clients will be served through the Health Insurance Continuation Program.

**Supportive Services Program:**

**Goal:** To ensure that a continuum of supportive services are available that link persons living with HIV disease into primary medical care.

- Objective: On an annual basis, 750 unduplicated clients will be served through the Supportive Services Program.

**Administration/Planning and Evaluation/Quality Management:**

**Goal:** To ensure compliance with the legislative requirements of the Ryan White CARE Act.

- Objective #1: On an annual basis the Title II grantee will comply with all conditions of grant award.

- Objective #2: On an annual basis the Title II grantee will comply with all Ryan White Care Act Agreements and Assurances.

- Objective #3: On an annual basis the Title II grantee will engage in a public advisory planning process including convening the Treatment and Care Planning Committee and holding public information meetings for the purpose of developing a comprehensive plan and commenting on the implementation of such plan.

- Objective #4: The Title II grantee will implement and develop the Statewide Coordinated Statement of Need (SCSN) as defined in the guidance by the Health Resources and Services Administration (HRSA). The grantee will review and update the SCSN at least every three years.

- Objective #5: The Title II grantee will establish a quality management program to assess the extent to which HIV health services provided to patients under this grant are consistent with the most current guidelines for treatment of HIV disease and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

- Objective #6: The Title II grantee will provide for periodic independent peer review to assess the quality and appropriateness of health and support services provided by entities that receive funds from the State under Title II.

- Objective #7: On an annual basis the Title II grantee will submit the annual administrative report to HRSA.

- Objective #8: On a semi-annual basis the Title II grantee will conduct a program needs assessment.

- Objective #9: On an annual basis the Title II grantee will conduct program evaluation activities.

- Objective #10: On a semi-annual basis, the Title II grantee will conduct a customer-satisfaction survey.

**Goal:** To identify PLWH/A who are not in care and bring them into care.

- Objective: Conduct a modified RARE (Rapid Assessment Research & Evaluation) study in the summer of 2003. This study should enable the Title II grantee to identify PLWH/A by the following four groups:
    1) In Care, In System
    2) In Care, Out of System (access services other than Ryan White Care Act)
    3) Out of Care, In System (Access services, but not primary medical services or not within the past six months)
    4) Never In Care

**Goal**: To continue improving the efforts of the Statewide HIV Planning Advisory Council, which is comprised of the HIV Prevention Community Planning Committee and the HIV Treatment and Care Planning Committee.

- Objective #1: On a quarterly basis, the Prevention for Positives subcommittee, made up of members from both the HIV Prevention Community Planning Committee and the HIV Treatment and Care Planning Committee will meet to discuss “HIV Prevention for People Living With HIV/AIDS” - HRSA’s term for Prevention for Positives.

- Objective #2: Integrate the efforts of the HIV Prevention and the HIV Treatment and Care Comprehensive Plans for a 3-year cycle for the 2004 fiscal year.

**Goal:** To further identify PLWH/A by using HRSA’s defined Severe Need subpopulations, with definitions of service specific to: use, need, barrier, gaps and demographic measures.

- Objective: Conduct a modified RARE (Rapid Assessment Research & Evaluation) study in the summer of 2003.

**Goal:** To further integrate the Utah Department of Health, Bureau of Communicable Disease Control, HIV/AIDS Treatment & Care Program with the Department of Human Services, Division of Substance Abuse and Mental Health Services

- Objective #1: Further research substance abuse issues for all PLWH/A and by severe need subpopulation level.

- Objective #2: Determine the extent to which lack of access to this service prevents "Aware and not in Care" in historically underserved or unserved subpopulations from seeking substance abuse services.

## SECTION C MONITORING OUR PROGRESS

Evaluation is one of the fundamental elements of the Comprehensive HIV/AIDS Plan. The Treatment and Care Planning Committee and the Utah Department of Health, Bureau of Communicable Disease Control have the primary responsibility for monitoring the progress of the Comprehensive HIV/AIDS Plan's implementation. These two entities will monitor the progress toward achievement of the goals and objectives, continue to gather information and update the Comprehensive HIV/AIDS Plan every three years, and evaluate its own process during the creation of the Comprehensive HIV/AIDS Plan and as the Comprehensive HIV/AIDS Plan is implemented during the next year.

The following sections describe how monitoring will take place in four areas: 1) achieving goals and objectives; 2) monitoring changes in the epidemic, client's service needs, and service availability; 3) monitoring changes in legislation, technology, and delivery systems; and 4) revisions to the Comprehensive HIV/AIDS Plan.

## I. Achieving Goals and Objectives

The HIV Treatment and Care Planning Committee will work in conjunction with the Utah Department of Health, Bureau of Communicable Disease Control to periodically review the status of each objective to ensure that all objectives are being achieved in a timely manner. If problems arise in the meeting of goals and objectives, the HIV Treatment and Care Planning Committee will revise and rewrite any of the goals and objectives considered to be unsuitable/unworkable. Once approved by the HIV Treatment and Care Planning Committee, these changes will be incorporated into the Comprehensive HIV/AIDS Plan. The HIV Treatment and Care Planning Committee will also compare the goals and objectives to the changing trends in the epidemic and the changing needs of clients and make recommendations/revisions as needed.

The following is a progress report of the 2001-2002 Goals and Objectives:

**AIDS Drug Assistance Program:**

Goal: To ensure that medications are available to persons living with HIV disease.

Objective: On an annual basis, 250 unduplicated clients will be served through the AIDS Drug Assistance Program.

- *During the reporting period from April 1, 2001 to March 31, 2002 the AIDS Drug Assistance Program served 230 persons.*

**Home Health Care Program:**

Goal: To ensure that home and community based care services are available in order to reduce hospitalizations for persons living with HIV disease.

Objective: On an annual basis, 10 unduplicated clients will be served through the Home Health Care Program.

- *During the reporting period from April 1, 2001 to March 31, 2002 the Home Health Care Program served 9 persons.*

**Health Insurance Continuation Program:**

Goal: To ensure that Health Insurance Continuation services are available to provide health insurance coverage to persons living with HIV disease.

Objective: On an annual basis, 150 unduplicated clients will be served through the Health Insurance Continuation Program.

- *During the reporting period from April 1, 2001 to March 31, 2002 the Health Insurance Continuation Program served 153 persons.*

**Supportive Services Program:**

Goal: To ensure that a continuum of supportive services are available that link persons living with HIV disease into primary medical care.

Objective: On an annual basis, 550 unduplicated clients will be served through the Supportive Services Program.

- *During the reporting period from April 1, 2001 to March 31, 2002 the Supportive Services Program served 498 persons.*

**Administration/Planning and Evaluation/Quality Management:**

Goal: To ensure compliance with the legislative requirements of the Ryan White CARE Act.

Objective #1: On an annual basis the Title II grantee will comply with all conditions of grant award.

- *The Title II grantee (Utah Department of Health) met all conditions of the grant award for April 01, 2001 to March 31, 2002.*

Objective #2: On an annual basis the Title II grantee will comply with all Ryan White Care Act Agreements and Assurances.

- *The Title II grantee (Utah Department of Health) met all agreements and assurances associated with the Ryan White Care Act.*

Objective #3: On an annual basis the Title II grantee will engage in a public advisory planning process including convening the Treatment and Care Planning Committee and holding public information meetings for the purpose of developing a comprehensive plan and commenting on the implementation of such plan.

- *A public information meeting was held in January 2002.*

Objective #4: The Title II grantee will implement and develop the Statewide Coordinated Statement of Need (SCSN) as defined in the guidance by the Health Resources and Services Administration (HRSA). The grantee will review and update the SCSN at least every three years.

- *The SCSN was last updated in September 2000 and is not due for review again until September 2003.*

Objective #5: The Title II grantee will establish a quality management program to assess the extent to which HIV health services provided to patients under this grant are consistent with the most current guidelines for treatment of HIV disease and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

- *The Title II grantee (Utah Department of Health) has contracted with HealthInsight to establish a quality management program. The program has been developed and is in the primary stages of being implemented.*

Objective #6: The Title II grantee will provide for periodic independent peer review to assess the quality and appropriateness of health and support services provided by entities that receive funds from the State under Title II.

- *Please see Quality Management objective.*

Objective #7: On an annual basis the Title II grantee will submit the annual administrative report to HRSA.

- *The Title II grantee (Utah Department of Health) has submitted the annual administrative report to HRSA.*

Objective #8: On a semi-annual basis the Title II grantee will conduct a program needs assessment.

- *The Title II grantee (Utah Department of Health) conducted a program needs assessment in the spring of 2000 and is currently working on a needs assessment for the summer of 2002.*

Objective #9: On an annual basis the Title II grantee will conduct program evaluation activities.

- *The Title II grantee (Utah Department of Health) is in the process of developing a program evaluation plan.*

# I. Monitoring Changes in the Epidemic, Clients' Service Needs, and Service Availability

### *Monitoring Changes in the Epidemic*

Cases of HIV infection and AIDS are monitored by the AIDS Surveillance Program Manager in the Utah Department of Health, Bureau of Communicable Disease Control on a monthly basis, and epidemiologic trends are monitored annually. The annual HIV Surveillance Report and Community Epidemiological Profile provides information about HIV Infection and AIDS by exposure category, ethnicity, sex, age, and geographic distribution of cases.

The HIV Treatment and Care Planning Committee will monitor the epidemic by reviewing surveillance data and other demographic information, such as income, employment, health insurance, and housing. From this information, the Comprehensive HIV/AIDS Plan will be periodically modified as the epidemic continues to change.

### *Client Service Needs*

Specific goals and objectives have been designed to monitor the degree to which Ryan White Title II funded agencies are meeting the service needs of clients. Client satisfaction surveys and other evaluative tools will be implemented semi-annually. The HIV Treatment and Care Planning Committee will have the responsibility of monitoring this process by reviewing client evaluations and making recommendations to the Utah Department of Health, Bureau of Communicable Disease Control.

### *Service Availability*

Specific goals and objectives have been designed to improve the availability of services to clients by Title II funded agencies. Provider evaluations will be implemented annually to assess the delivery system, and will reflect the guiding principles established in this Comprehensive HIV/AIDS Plan for the system of care. The evaluations will ensure that:

- The care is client-centered.
- The care is comprehensive and inclusive of a wide variety of client needs.
- The care is of the highest quality possible.
- The service providers treat the client in a respectful, dignified manner.

- The services are sustained and supported by other providers in the community.
- The care is designed to be accessible to all persons with HIV/AIDS.

The role of the Treatment and Care Planning Committee is to analyze the results of the provider evaluations and make recommendations to the Utah Department of Health, Bureau of Communicable Disease Control to ensure the highest level of service availability within the fiscal resources of Title II funding.

A statewide resource directory, created by the Utah Department of Health, Bureau of Communicable Disease Control, contains information specific to the two main areas of the state: the Wasatch Front and the rural/outlying counties. The resource directory will provide up to date service information to case managers and client advocates, which will ultimately assist clients to obtain care services that meet individual needs.

## II. Monitoring Changes in Legislation, Technology, and Service Delivery Systems

### *Legislation*

With the exception of Medicaid dollars, the majority of HIV/AIDS care services in Utah are provided with federal funds from Ryan White Titles II, III, and Part F Programs and HOPWA. The funds available for HIV/AIDS care are inadequate when compared to the needs of the clients. Therefore, any changes that increase or decrease funds on a federal, state, and/or local level will have significant impact upon the service delivery system.

Changes in legislation that affect funding will be reviewed by the HIV Treatment and Care Planning Committee or the Resource Allocation Subcommittee. Through periodic review, future changes may be anticipated so recommendations may be made to expand or decrease services in accordance with legislative changes.

### *Technology/Development*

Rapid advances in treatment and FDA approved medications are having an impact upon the quality and quantity of life for people living with HIV disease. However, if new medications are to be purchased with Title II funds, less money will be available for other services.

The HIV Treatment and Care Planning Committee and AIDS Drug Assistance Program Subcommittee will periodically review this information, keeping the State formulary up to date.

### *Service Delivery Systems*

Changes in the delivery of services in the two main areas of the state, the Wasatch Front and rural/outlying counties will have an impact upon the health of individuals with HIV disease accessing services in those areas.

The role of the HIV Treatment and Care Planning Committee is to monitor the service delivery systems and make recommendations for cost-effective improvements, based on the values established in the Comprehensive HIV/AIDS Plan for the delivery system of care (client-centered, comprehensive, high quality, respectful, supported by other providers, and accessible to all persons with HIV/AIDS).

## IV. Revisions to the Comprehensive HIV/AIDS Plan

***Role of the HIV Treatment and Care Planning Committee***

During the first quarter of 2003, the HIV Treatment and Care Planning Committee will begin to implement the Comprehensive HIV/AIDS Plan. The existing subcommittees (Executive, Policy & Procedure, Resource Allocation & Evaluation, Needs Assessment, Membership, Goals & Objectives, Quality Improvement and Comprehensive Plan) will continue with designated tasks. Additional subcommittees will be formed to divide the remaining work, ensuring that all elements of the Comprehensive HIV/AIDS Plan are fulfilled.

During the third quarter of 2003 the HIV Treatment and Care Planning Committee will review, evaluate and make revisions to the Comprehensive HIV/AIDS Plan, utilizing the information gathered under subcategories I, II, III above.

***Role of the Utah Department of Health Bureau of HIV/AIDS Treatment and Care Program***

The Treatment and Care Program will provide the following assistance to the Treatment and Care Planning Committee:

- Staff assistance for the logistical and clerical operations of the Treatment and Care Planning Committee and its subcommittees.
- Technical expertise with respect to the Ryan White CARE Act, budget information, and Title II funded agencies.
- Staff assistance for yearly revisions to the Comprehensive HIV/AIDS Plan.
- Linkage between the service provider network and the Treatment and Care Planning Committee to provide information useful for the decision-making process.
- Provision of epidemiologic, demographic, and needs assessment information as needed by the Treatment and Care Planning Committee for making decisions.

This section has established a foundation about monitoring and evaluating the planning process, as well as the Comprehensive HIV/AIDS Plan itself. Through evaluation, achievements and weaknesses will be identified as the groups work together to meet the goals and objectives of this Comprehensive HIV/AIDS Plan.